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Vol. XXXIX NOVEMBER, 1932 No. 5

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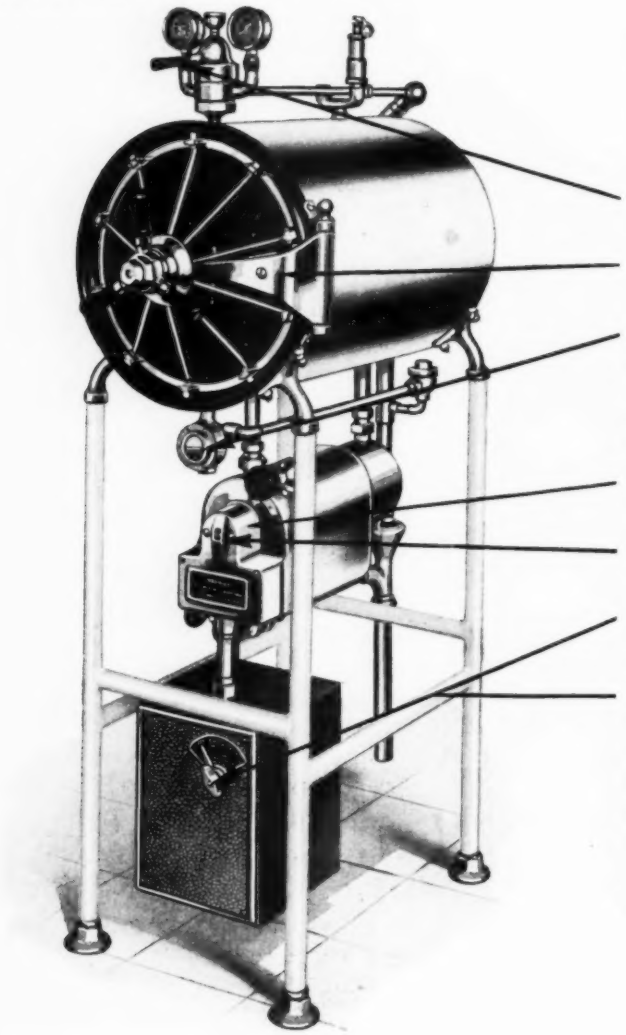

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THE MODERN HOSPITAL

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Politics, Politicians and Hospitals

A Paper From the American Hospital Association Meeting

By JOSEPH C. DOANE, M.D.
Medical Director, Jewish Hospital, Philadelphia

IN a monograph describing the characters and characteristics of the ancient Philadelphia Hospital, the distinguished and brilliant Dr. Chalmers Da Costa remarked on certain attributes of the board of the guardians of the poor, as it functioned one-half century ago in administering the city's hospital.

With sarcasm, scimitarlike in its cutting edge, he stated that this board was so denominated because it had done some of the poorest guarding of the pauper's interest on record and that the politician of that day and I presume of this day too, resembled a corkscrew, in that the crookeder he was the stronger pull he had and that the members of the board of this hospital at one time or another looked strangely undressed when their wrists were unadorned with manacles. True to fact were many of these statements because history relates that the hospital politician of olden days was cunningly corrupt, stocking his own larder from the storehouse of the institution and on one occasion even substituting a tin for a copper roof, because the latter brought more from the local junk dealer.

The scandals that have been connected in the past with the administration of institutions, particularly governmental institutions, are almost unbelievable in the light of the present day. Mismanagement, due to the interference of the petty politician, and inefficiency, due to the indifferent attitude of the public as to the fate of the charges of public institutions, were responsible for delay in the recognition that such hospitals should not be allowed to exist as unsafe and mismanaged institutions but that the medical care of their patients should be in no way inferior to that supplied by private hospitals. Rarely, nowadays, do political shysters steal hospital roofs and appropriate institutional funds and supplies—at least, it may be said rarely are they caught at it. And yet it may be stated with a great deal of truth that there is not a municipal, county, state or even federal hospital in which to some degree the efficiency of the institution is not lessened because behind the scenes political wires are being pulled.

As to definition, petty politics consists of one selfish, greedy and often ignorant man, trying to obtain, clandestinely or sometimes in the broad light of day, something for himself from another cowardly, greedy and equally ignorant person. However, the exception often proves the rule for sometimes those concerned are more dangerous because they possess some education.

From a practical standpoint, the methods by which municipal and county politicians touch the local hospital vary almost as greatly as do the geographic locations of these institutions. In most

such locations the political complexion changes on an average from two to four years, the superintendent of the hospital and his organization being affected in some degree by the ebb and flow of political fortunes. At times the local institution becomes involved in the preliminary political campaign. The astute politician in deciding the methods to be adopted in his campaign looks about for something concerning which to complain. He must have a slogan and a program with which to arouse from the somnolence of the past few years the voters who are not included in the group of faithful who will ballot as they are told.

The Public Is Easily Fooled

His eyes light upon the city hospital and his first step is to find in this organization someone willing to furnish him his implements of war. Sometimes this person has been acting as assistant superintendent or he may be the chief engineer or he may be one of the nondescript workers about the hospital. If the assistant superintendent is chosen, he usually is promised promotion to the charge of the hospital, if the campaign succeeds. Perhaps in such campaign attacks the confidence of the public is most shaken in the methods and administration of their hospital. Newspapers avidly seize upon such attacks and the public, led to believe that all is not well with the treatment of the indigent sick, little suspects the motives that actuate the campaigners against hospital authorities.

We look about us and find no difficulty in observing cities and counties bankrupt and unable to meet their pay rolls, and the hospital, of course, suffers from every angle. The day has now departed when patients can be treated efficiently in the municipal and county hospital for one or two dollars a day. And yet political breasts swell with pride when it is pointed out that even in better days patients were being maintained at an impossibly low figure. Even in the better conducted governmental institutions, if one looks deep enough, there will be found a tendency to interfere politically by such methods as requiring that all appointments be made at the city hall and not by the superintendent, by insisting that certain favored ones be permitted leaves of absence, particularly on election day, by placing in private rooms friends or relatives of those in power and insisting that they receive special privileges without cost. Of course, the maintenance of a group in power depends upon interesting sufficiently those who have been given suffrage. Votes may be secured in many ways—by gratuities, by giving employment, by supplying food, coal and other necessities—but the money necessary for this purpose finds its origin not in the pocket of the generous politician but by requiring contributions from workers. It is easy to dispense the money of other people with a free hand.

The glory of maintaining the traditions of the party in or out of power, the call to the colors is often but the blatant squawk of a man or a group of men who long for the fleshpots of power and for the pelf that they will bring. The part the tax supported hospital is expected to play in some measure or another in the political plan of the average community is to provide jobs or gratuitous medical service on demand for those who temporarily have been given the authority to order that this be done. How blind is a political system that is satisfied with such minor personal advantages, when from a vote-getting angle alone the highly ethical, well run institution is the greatest political asset a party may have.

No doubt some may be irritated by the harshness—the brutality, if you please—of these remarks. I intend no offense in thus castigating a political system that permits interference with the work of the hospital. In speaking of the characteristics of the individual of the system, the politician, let me remind you that I number not a few of the professional type among my friends. They are prone to be generous, much moved by the ills of others and often they are wholesome fellows always ready for picnic, party or for political combat. But they are but pawns of a corrupt system maintaining their positions only as long as they can supply the pabulum of the political life of their superiors—votes. Many are proudly pointed out as self-made men. I have often thought that most of these were not so resplendent a manufactured article at that.

A Few Cold Facts

But he who controls a city division must look to the ward leader and the latter to the members of the central committee for promotion or preferment. He is not always ignorant or vicious. He usually is blatant, selfish and frequently dull as a dinner companion. He does not look for trouble and prefers that all should be serene, each party securing from the long-suffering taxpayer as much unearned increment as possible without controversy. He lauds the people as the god which he worships. He mortally fears the press, and such words as probe-investigation or taxpayers' suits strike fear to his flabby soul. His walls are usually not papered with diplomas. In one hospital, when it was once remarked that a certain paint was necessary to give warmth to the rooms, a member of the genus politician coyly asked if the heating system was not efficient—and this from a self-made man.

Public hospital purchasing has always presented many difficulties to the superintendent of this type of institution. Usually the executive is required to send requisitions to a city purchasing agent who in turn makes contact with wholesalers and arranges the purchase. The efficiency of the whole system, which is certainly theoretically correct, depends on the training and honesty of the officer designated to make the purchases. If the latter is incorruptible and if his superior officer supports him, all may be well. But a vacillating and flabby mayor and a money hungry purchasing agent comprise a team that should strike terror into the heart of the superintendent of any governmental institution. Can you imagine an ignorant grafting buyer coolly informing a highly experienced superintendent of nurses that she needs 72 by 80-inch sheets when weeks of inquiry and study had convinced her that 90 by 105-inch were more efficient? Would you believe that in order to evade buying good rubber sheeting and so as to substitute an inferior grade at an exorbitant price some highly skilled purchasing agent started a story that the assistant superintendent was a relative of the manufacturer? Would you think it possible that a contractor could afford to offer a $10,000 bribe to one who, he thought, could secure a $75,000 supply contract for him? Yet these identical incidents have occurred in my experience.

Things as They Should Be

But there came to this hospital an honest business man, well trained and with ample spinal rigidity, an occurrence that was at once as confidence inspiring as it was unusual. He cast out the grafters and office misfits. He drew up hard and fast specifications. He turned a deaf ear to suggestions of self-styled friends of the administration to soften their requirements. The shyster bidder was forced to seek greener pastures. Legitimate bidders who would not stoop to graft sought city business because they became convinced that quality would be recognized and the local governmental hospital secured good supplies at a fair price. The old game of delivering after much delay a consignment of inferior surgeons' gloves, for example, and hoping that the exigency of the case would force their use, was no longer employed. Frozen chickens were no longer delivered a few hours before they were needed and Friday did not see ancient fish brought to the hospital at 10 a.m. One can feel but scant pity for the shysters who lost money and their right to bid for city business because of the fortitude of this purchasing agent.

Perhaps as devastating in its effect on the hospital patient is the lowered morale that results when places are demanded for untrained hospital workers. A social service department containing both political appointees and those who secured their places on merit will not long enjoy the services of the latter group. The drunken orderly discharged by the superintendent before dinner and sent back to work with a note from his ward leader before breakfast, the storekeeper who was a failure behind a cigar counter until he stumped for a successful aspirant for the mayoralty, all are examples of the evil effect on hospital organization of a meddling political machine. The superintendent must be given the right to engage and discharge all employees under his direction, subject to any civil service regulations that may exist. This is a *sine qua non* of good administration of a public hospital.

A Pitiful Spectacle

In not a few cities there has been set up an office in the municipal building from which all patronage is dispensed and to which the hospital executive must apply for hospital workers. Such a system may be politically expedient but it is fatal in its effect on hospital morale. Qualifications should certainly be outlined to cover every position in the hospital, but the superintendent's judgment must, in many instances, be the deciding factor in accepting an applicant. One of the beneficial effects of the present economic condition is that an opportunity has been afforded the hospital executive to dispense with the service of misfits.

Perhaps the most blighting influence of hospital politics is that exerted on the superintendent. He may undertake his work in his early days of governmental service with high enthusiasm and a firm resolve to allow nothing to interfere with the proper care of the patient. Courteously but firmly he rejects any overtures for the recognition of the demands of patronage, insisting on high qualifications for all those who are to deal with the sick. Sometimes he is tempted with gifts or invitations which, if he accepts them, generate a friendliness with the politician which later may lead the superintendent to relinquish his resolve to grant special favors to none. Again, his resolve is often weakened through sheer weariness of combat. Moreover, the longer the executive serves the more dependent he and his growing family become on the salary that he receives. He salves his conscience with the statement that the good soldier obeys orders and that his duty is not to question why. There is no more pitiful spectacle than the hitherto stalwart efficient executive who has degenerated to the extent of being willing to sacrifice his principles in order to hold his position.

Thus far I have painted the picture with somber tints. In many hospitals it but poorly depicts the dismal details of the politically blighted institution. There are splendid exceptions, as has been indicated, of municipal and county general hospitals, that reflect credit on their managers and on their communities. There are mayors and governors of high vision and great constancy of purpose. There are commissioners of hospitals and health who decree that the hospitals under their charge shall not be soiled by the touch of the politician. Such institutions should receive the commendation and approval of the great surgical, medical and hospital associations. The corrupt institution should be publicly condemned. Thus and only thus can the cowardly practices of the professional politician be checked even though his soul is not purged. The many thousands of patients being treated in hospitals rendered inefficient by political interference cry out for relief. It is the duty of the American Hospital Association to show the way.

An Administration Code Is Needed

As a practical solution of some of the problems of the governmental hospital it has been found expedient in some localities for these institutions to be administered by a board of trustees appointed by such a group as a board of judges or some other nonpartisan nonpolitical body. In some states, the state owned hospitals for the care of the mentally ill are supervised by a board of trustees appointed by the governor and residing in the community in which the hospital is located. This system has been found to work well. In some cases, however, a governor desiring to utilize the powers of his office for political advancement has removed any autonomous powers from this board. In such instances, all appointments must be approved by a representative of the government and all purchases made by a state purchasing agent. The beneficial effects of the local board of trustees are thus rendered null and void. Moreover, while the theory of a central purchasing system, as has been remarked, is sound, the practical application of this procedure is of doubtful advantage. The goods are delayed in delivery, substitutions are made, not wholly in the interest of economy but perhaps to the advantage of some political group. The purchasing agent assumes an autocratic attitude and the morale of the hospital superintendent is destroyed.

The administration of governmental hospitals should not be disturbed every time a political campaign is inaugurated. The morale of hospital workers who are in doubt as to what the next elected or appointed official will do is lowered. Such persons at each political change endeavor to gain influence with the incoming administration at the expense of loyalty to the hospital and its superintendent. They are inclined to feel that the authority of the superintendent is of little moment and that the new administration will determine the permanence of all members of the personnel.

A joint committee representing the American Medical Association, Americal Hospital Association and the American College of Surgeons could well be formed to outline approved administration methods for governmental hospitals. If a nonpartisan board of trustees of outstanding business, social and even professional representatives could be placed it would add permanence and stability to the administration of county, state and city hospitals. No mayor or medical commissioner of health can be adequately hospital-minded or trained. A board of trustees, not affected by the political dictates of the mayor or any of his appointed officers, would act as a buffer which would stop the entrance of petty politics into the hospital. The education of the community as to the type of service to be expected of municipal institutions would in a large measure prevent such abuses as the exploitation of hospital service in order to dispense favors.

This information given in this paper is not drawn entirely from my personal experience and it is not to be looked upon in any measure as the complaint of one who has had disappointments at the hand of the city politician. I was fortunate in serving a decade and a half in an institution to which politics was a stranger. I have, however, had the opportunity to observe splendid institutions withering under the effect of its pernicious system. If the American Hospital Association does not assume the position of leadership in stopping a practice which if not actually causing the loss of life certainly lowers efficiency and hence prolongs disability, then it will not have justified its existence as a leader of hospital thought in this country.

Hospital Opens Store—Business Is "Booming"

An example of successful operation of a store in connection with a hospital is found at Guy's Hospital, London. This shop, which is stocked to supply every need of the patients in the wards, has been opened only a short time but already is reported to be doing a splendid business. Friends of patients rely on it for gifts on visiting days. The prices charged are the same as those charged for the same commodities in other stores. The hospital expects to make a substantial profit each year as soon as the initial cost is paid off.

Solving the Food Service Problem in a Soldiers' Home

By HARRY L. MEAD
Architect, Grand Rapids, Mich.

THE Michigan Soldiers' Home, Grand Rapids, comprises a group of buildings, the principal units of which are the main building housing men and the administration offices, two women's buildings housing widows of veterans, the power plant, an employees' dormitory building and a hospital.

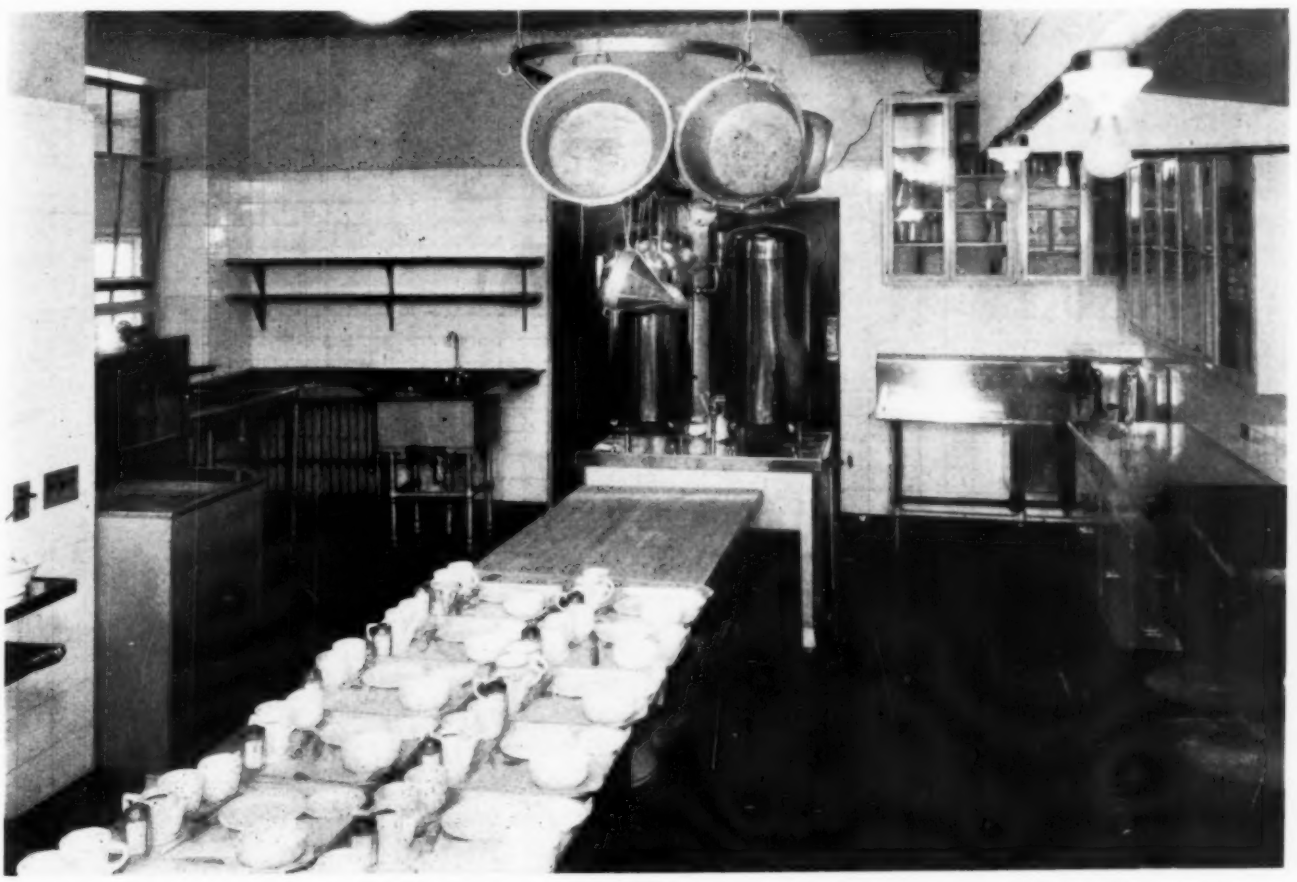
At present there are 527 residents, or members as they are termed, of the institution. Of these, 339 are men and 188 are women. In addition, there are 112 employees who are nonmembers.

The buildings were erected at various dates beginning in 1886. Prior to the comprehensive rehabilitation of the buildings, which was begun in 1928 under the administration of the present commandant, Col. Edgar H. Campbell, there were three separate kitchens—one in the main building, one in the women's building and one in the hospital.

Commissary supplies were formerly stored in various buildings and locations and baking was done in an antiquated structure attached to one of the buildings, with almost no provision for the cold storage of supplies.

It was desired to concentrate the storage of food and other supplies under the supervision of one officer and to perform all cooking and baking at one point to serve all members and employees of the institution. To this end a survey was made under the direction of George R. Thompson, budget director of the state administrative board.

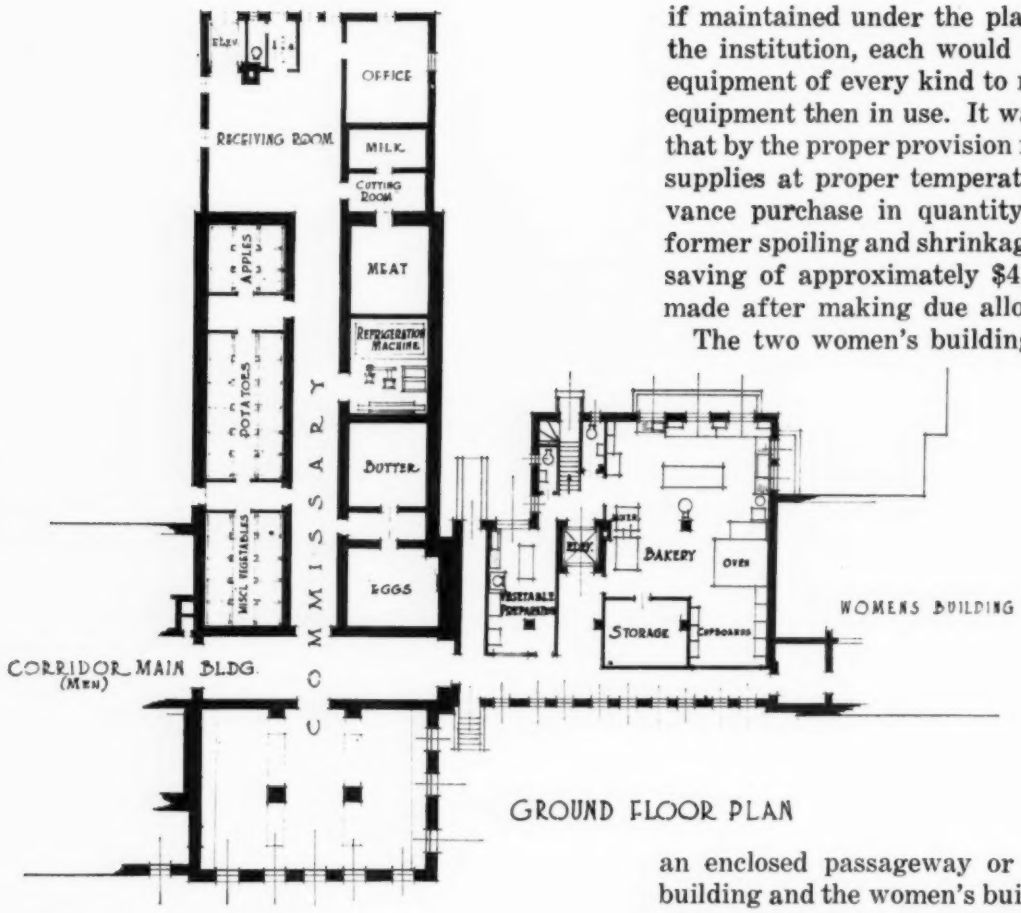
It was found that each of the three separate kitchens required a full quota of employees and,



Food prepared in the main kitchen is sent to this service kitchen and from here served to the hospital patients.

if maintained under the plan of rehabilitation of the institution, each would require complete new equipment of every kind to replace the antiquated equipment then in use. It was further determined that by the proper provision for the storage of food supplies at proper temperatures allowing for advance purchase in quantity and eliminating the former spoiling and shrinkage of supplies, a known saving of approximately $4,500 a year would be made after making due allowance for operation.

The two women's buildings were connected by

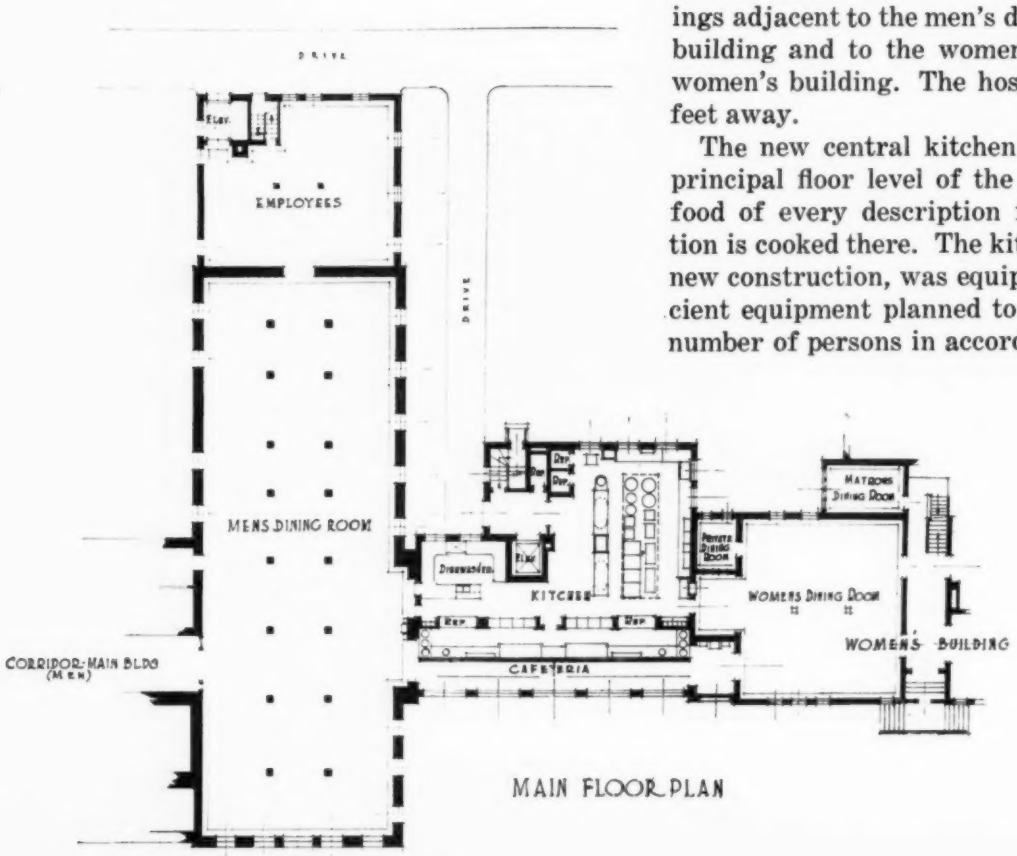


GROUND FLOOR PLAN

On the ground floor below the men's dining room a receiving department has been placed, together with storage space for food supplies and refrigerated rooms for vegetables, fruit, eggs, butter, milk and meats. All baking is done in the central bakery shown in the plan.

an enclosed passageway or corridor. The main building and the women's building were some fifty-seven feet apart and a location was selected for the new central kitchen between these two buildings adjacent to the men's dining room in the main building and to the women's dining room in the women's building. The hospital building is 1,500 feet away.

The new central kitchen was arranged on the principal floor level of the two buildings and all food of every description for the entire institution is cooked there. The kitchen, being of entirely new construction, was equipped with new and efficient equipment planned to care for an increased number of persons in accordance with the govern-



MAIN FLOOR PLAN

Food is served to the men and women in their respective dining rooms through the cafeteria shown in the plan. The room is equipped with a modern serving counter of stainless metal and enamel. From this cafeteria are served 283 men and 108 women, as well as 112 employees.

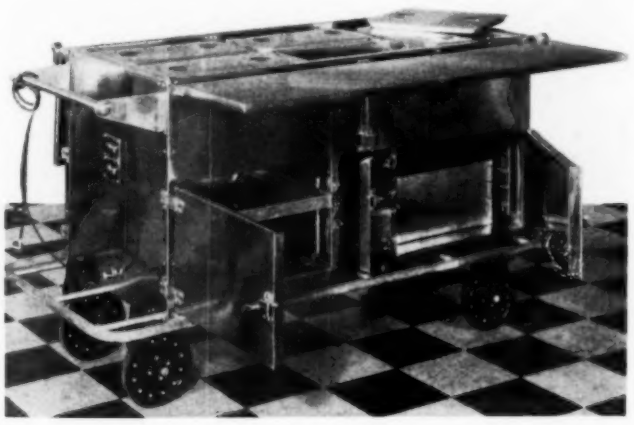
ment's forecast of the probable future peak number of veterans who will be cared for in institutions of this type.

Food is served to the men and women in the adjacent dining rooms through the cafeteria shown on the plan of the main floor. The room is equipped with a modern serving counter with steam heated food compartments, shelves and space for pastry, ice cream compartments and coffee urns, all in duplicate, starting from the center of the counter. Back of the counter are the customary cabinets and refrigerators accessible from both the front and the back. These items of equipment are of stainless metal and enamel.

From this cafeteria there are served at present 283 men and 108 women together with the 112 employees whose dining room adjoins the men's dining room. Dishwashing for the men's and women's dining rooms is done in the main kitchen.

All baking for the institution is done in the new central bakery on the ground floor below the kitchen. This department is equipped with new and modern baking equipment and provides for present and probable future needs.

On the ground floor below the men's and employees' dining rooms a receiving department was arranged together with storage space for food supplies and refrigerated rooms for the various kinds of vegetables, fruit, eggs, butter, milk and meats. This department is in charge of the quartermaster and is convenient to the bakery and

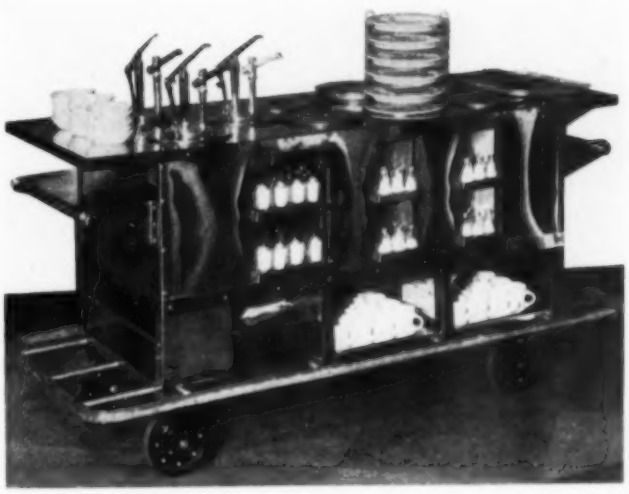


Food cooked in main kitchen goes to the serving kitchen in bulk in this electrically heated truck.

vegetable preparation room. It serves the main kitchen by means of an elevator.

The hospital building under the program of rehabilitation was completely rearranged and reconstructed as to interior appointments, partitions, floors, plastering, equipment and finish, thus increasing its former capacity of 180 beds to a normal capacity of 300 beds. A new serving kitchen was provided and furnished with modern equipment and the several dining rooms in the building were replaced with one new dining room on the main floor adjacent to the serving kitchen.

There are at present fifty-six men and eighty women patients who, for the purpose of serving food, are divided into three classifications: (1) the bed patients in wards on the main floor; (2) the

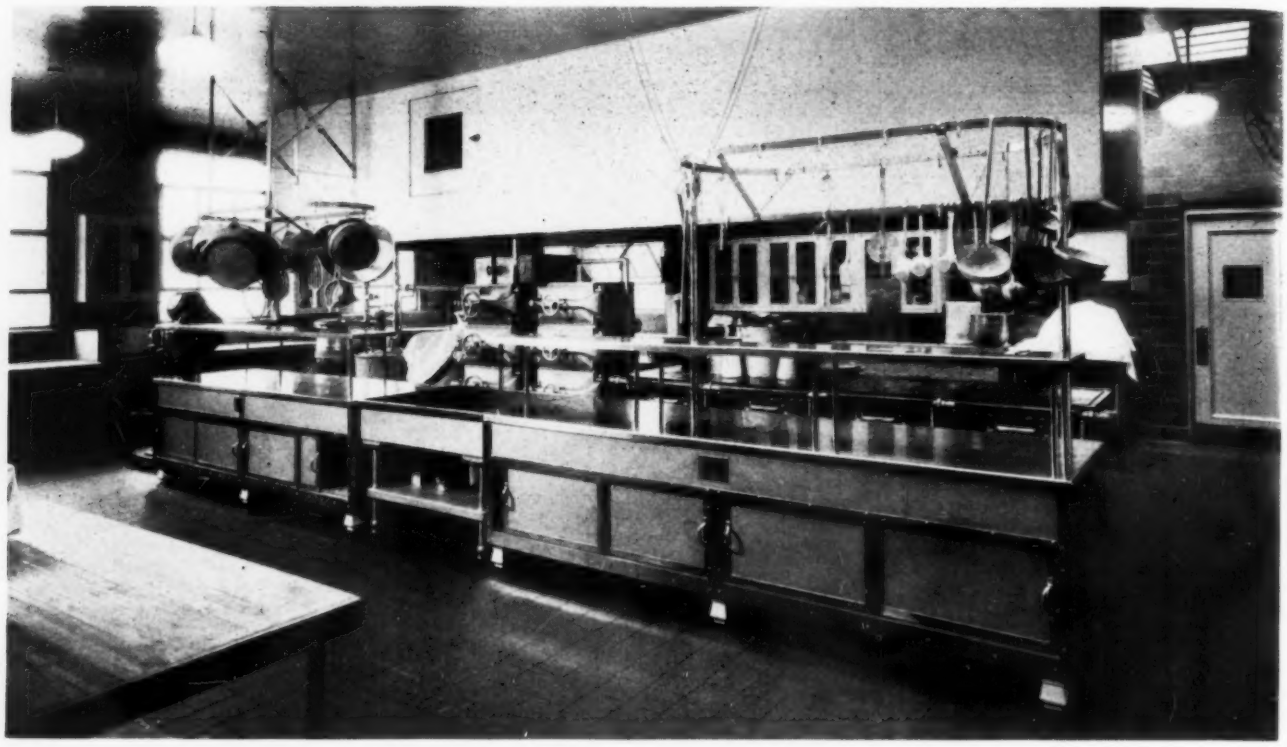


Ward patients on the main floor are served from this type of electrically heated truck.

ambulatory patients on the second, third and fourth floors, all of whom are served at tables in the general dining room on the main floor, these patients generally being those who have become too infirm to remain in the general men's and women's buildings of the institution; (3) the occasional sick person among the ambulatory patients who temporarily has to be served at the bedside. All hospital employees including doctors, nurses and others are served at the central employees' dining room in the main building.

Food for the hospital is cooked in the main kitchen and is delivered to the hospital serving kitchen in bulk in electrically heated food trucks. These trucks are of stainless metal and the containers are all removable, the food, insofar as possible, being cooked or prepared in the containers and immediately transferred to the trucks which are transported to the hospital in an auto truck. Plug receptacles are provided in both kitchens so that heat is maintained at all times, and the trucks have covers and are insulated heavily all around.

The table service in the hospital dining room is done in "family style." The meats and vegetables are placed on the tables in large dishes. For this purpose the food trucks are often brought directly into the dining room immediately before meal time and the dishes filled directly from the



All food of every description for the entire institution is prepared in the main kitchen, illustrated above. Of entirely new construction, this kitchen is equipped with modern and efficient equipment planned to care for an increasing number of persons. The hospital dining room pictured below is typical of all the institution's dining rooms.

containers in the trucks, a procedure which eliminates one handling of the food.

Hospital bed patients in the wards on the main floor of this building are served by means of another type of food truck. These trucks are of stainless metal, heavily insulated and electrically heated, plug receptacles being provided for the purpose both in the serving kitchen and at intervals in the wards. There are compartments for clean trays, silverware, sugar bowls, creamers, cups, all additional dishes and napkins. Food is served in compartment plates which are prepared in the serving kitchen and placed in tinned wire baskets in covered containers. Coffee, milk and tea water are carried in containers with pumps, and soups have separate containers with covers. Ice cream is carried in specially insulated containers. In the design of these trucks it was sought to do all placing of foods on the dishes in the serving kitchen rather than in the hospital wards in order to concentrate these details of work in the serving kitchen. In this way labor and confusion in the presence of the patient are avoided and the manner of serving is made more attractive.

Both types of food trucks were constructed from special designs prepared by the architect after an extended study by the commandant and the architect's staff of the food service problems peculiar to this institution.

How the Bed Patients Are Served

The occasional bed patients on the upper floors of the hospital, of which there are from twelve to twenty a day, are served by means of trays completely set up in the serving kitchen and dispatched by means of a high speed automatic electric service lift direct from the serving kitchen to the various floors. Here they are taken direct by attendants to the patient. An intercommunicating telephone system in the hospital makes direct communication possible from the nurses' stations to the serving kitchen. The trays are set up in advance of mealtime with tickets, silverware and linen and kept in a specially designed tray case adjacent to the service lift and serving point ready for the food which is placed thereon immediately before they are dispatched to the floors. Special diets that may be required are served in the same manner.

All dishes for the hospital are washed in a dishwasher in the serving kitchen, no dishes being exchanged between the main kitchen and the hospital serving kitchen.

It is possible to serve food piping hot to all patients even after it has been transported by the trucks or by means of the separate tray service.

The cafeteria service in the main building and in the women's building has been in operation for more than a year and has been successful, the persons in these buildings not having reached a condition of extreme infirmity. The hospital food service has been in operation for about eleven months and, together with other features of the food service plan of the institution, has given entire satisfaction to both officers and members of the institution. In addition it has materially reduced the cost of operation and has ensured cleanliness and attractiveness of service.

After All, Why Should Nursing Schools Close?

By Charles H. Young, M.D.
Director, Mountainside Hospital, Montclair, N. J.

"Too many young women are being educated in our schools of nursing," say the leaders in this branch of education. I believe this to be true. Equally true it would be to say "too many young women are being educated." Why specify schools of nursing? Why not include other schools?

I am beseiged by young women college graduates who seek work. Many of them are daughters of men formerly well-to-do, now victims of our incomprehensible economic system. Whatever esthetic or other value their education is giving them, in many situations it appears to be of little use in the cold practical business of making a living. The girl who has had a year at business college seems to have an advantage over these college women. The college and the business school girl work side by side and often the latter draws the higher pay.

While seeking recently for a young woman to fill an important position I interviewed candidates at a collegiate bureau of occupation and was amazed at the conditions I discovered. Many college graduates are working behind the counter as sales girls in our department stores and in other similar work in order to make a living.

Deplorable as conditions are among graduate nurses they are no worse than in other lines of endeavor. Distress seems rather evenly distributed. I believe the young woman who has had her training in a good school of nursing is a little better off today than the one who has been through college without being fitted for any specific industry. We meet no agitation for the closing of our colleges with appeals for employing those already graduated. Is it not possible that this energetic and persistent appeal on the part of our leaders in nurse education is ill advised?

Vital Issues of the Nursing Question and Ways to Meet Them*

A SPECIAL joint committee on nursing was appointed by the president of the Hospital Association of New York State, because of his firm belief that past reports have reflected opinions either of groups of nurse educators or of groups of hospital administrators, with no single report representing the "threshed out" opinions of both groups.

Appointed to serve on this committee are the presidents of the New York State Nurses' Association, the New York State League of Nursing Education and the New York State Organization for Public Health Nursing. The viewpoint of hospital administration is represented by three men, the superintendent of a large and important hospital in the metropolis, the superintendent of an up-state hospital, in what in comparison with New York City may be termed a rural section and a former president of the Hospital Association of New York State, who, though scarred from many previous bouts in this ancient battle between the financial needs of the hospital and the educational needs of the nurse, was nevertheless foolhardy enough to enter the ranks for another skirmish. This committee will be greatly pleased if it can make even a good beginning in solving some of the nursing problems that have proved to be such hardy perennials.

Hospital Deficits Are Increasing

Practicing physicians find that the depression has increased rather than lessened the volume of their work, but they report the country over an appalling shrinkage in income. The experience of the hospitals has followed closely that of the medical profession. The only plentiful commodity has been the applicants for hospital care at less than cost. The beautiful private patient pavilions, with their luxurious appointments, are shunned like a pestilence. Ward beds have been crowded as close together as the law allows, and only in these free sections of the hospital is business good.

Hospitals have always had deficits, and in the past a moderate deficit was considered an indication of good work. Now, however, the deficits are growing and that whole-hearted public support which formerly came to the hospital's rescue and balanced the deficit through generous donations is disappearing. The hospital's lay friends, instead of rolling in wealth, are genuinely concerned about their financial future and are less able to lend aid to the hospitals. Boards and committees weigh carefully every proposed expense and are of necessity curtailing the parts of hospital programs that are not indispensable.

Plight of Nurses Is Even Worse

In the face of all this comes a comparison made in New York City by the United Hospital Fund which indicates that, in spite of the lowered costs of many items hospitals use and in spite of some reductions in salaries the cost of caring for patients, at least in the group of hospitals studied, was more in 1931 than it was in 1929. The causes of this cannot be discussed at length, but those who are familiar with conditions fully realize that steady advances in medical science constantly increase the expense of giving up-to-date hospital care.

No further proof need be offered to show that the financial future of hospitals is not a bright one, and all will agree that clear and unbiased thinking is necessary on this nursing problem, as well as on other problems affecting hospitals.

On the other hand, the plight of the nursing profession is probably worse than that of the hospitals. Many thousands of nurses are said to be out of work, and the observations of most of the members of this committee bear out that statement. Private duty nurses, who have had constant employment for years, find themselves without work, with their savings exhausted and with no apparent solution to their problem. The hospitals in the metropolitan district have found that capable graduate nurses are willing to work for salaries that formerly they would have considered unworthy of their profession, and there are doubtless many instances of actual physical privation in the group of unemployed nurses.

Nursing education, on the other hand, in spite of danger signals revealed by intensive studies of its problems, which have gone on for years mainly under the auspices of the Committee on the Grad-

*A report of a special committee on nursing of the Hospital Association of New York State, presented at a meeting of the association in New York City, by the chairman of the committee, Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y.

ing of Nursing Schools, is going steadily on with the training and graduation of thousands of young women whose chances of employment when they have completed their nursing course seem uncertain, at best.

Number of Nurses Still Increases

The scarcity of jobs, the inability of parents to pay large sums for higher education for their daughters, are increasing the number of young women who clamor for entrance to schools of nursing. One can readily understand that even a discerning parent, though realizing the discouraging future in the nursing profession, might well feel justified in sending his daughter to a school of nursing. There she is assured, practically free of charge, of educational advantages that at least will do her no harm, whatever her occupation in after life, and the family can feel assured that for three years their daughter will not be a source of expense.

Formerly, labor turnover was a serious menace to the efficiency of institutions generally. To realize that labor turnover has practically ceased, one has but to study the employment records of any large hospital. Whereas in 1928 such a hospital might have experienced 100 changes a month in its pay roll it is safe to say that nowadays there are not ten such changes, and that a part of these ten will occur through the elimination of employees who are not replaced. This in itself is an index of the present saturation of the hospital employee field and gives an idea of the hopeless situation for the nurse who is unemployed and who seeks an institutional position.

Private duty nursing, as has been stated, has been seriously affected in the metropolitan district. A member of the committee, however, who is in a position to know facts, believes that there is still no overconcentration of nurses for private duty in the rural and semirural sections of New York State. During the busier portions of last winter, there were times when at his hospital nurses were not readily available either for private duty or for institutional work.

This brings us to the frequently expressed opinion that the trouble in the nursing profession is a matter of distribution rather than one of overproduction. It has long been contended that nurses prefer to work in the larger cities and would prefer to work there only part of the time rather than go to a rural section where employment is more nearly constant. The present situation should, it is believed, prove either the correctness or the fallacy of this assumption. The lack of nursing employment in the cities, with the privation that is resulting, will act as an inexorable force causing the migration of nurses to sections where they can secure work.

There is little doubt that this matter of distribution has been a factor in the difficulties of the profession. It is scarcely believable, however, that even if proper distribution were accomplished, there would not still be far too many nurses for the present times. Moreover, with continued flooding of the field with new graduates, better economic conditions in the future would still fail to provide work for all.

A report of the grading committee at a recent meeting of the National League of Nursing Education indicated that there is now one nurse for each sixty-three families in the United States. Certain states, such as New York, have a still higher concentration of nurses, but in forty of our states there is one nurse to 100 families or less. This report further states that by 1935 there will be 25,000 new graduates available, probably with no work to do. During the last decade the population of the United States increased 16 per cent; the number of nurses increased 97 per cent. In 1900, we had 11,000 nurses; in 1910, 82,000; in 1920, 149,000; in 1930, 294,000.

In its early deliberations the grading committee forecast the number of nurses for the years 1945 and 1965, should the increase in production continue as it had between 1910 and 1920. At present, thirteen states have already reached the quota predicted for 1945, and in some states the concentration of nurses per unit of population has equaled the prediction for 1965.

Must Face the Facts

It may not be generally agreed that the hospitals and the medical profession have entirely controlled the destinies of nursing. Most superintendents and boards of trustees can show that they have kept the good of the nurse and the nursing profession in mind in the development of their schools. Others will contend that nursing has long been a profession standing upon its own feet, and no one who has attended nursing meetings can deny that the nurses are an articulate group who have usually had the last word in discussions pertaining to their profession. In spite of all this, can the professions of medicine and hospital administration blind themselves to the obvious fact that we now have too many nurses and shall shortly have far too many?

We have often "growled" at the grading committee because its statistics have indicated the need of changes which we have been loath to make. We have sometimes refused to think these issues through and have judged national problems from the limited viewpoint of a single institution.

Many have conceded that there are too many nursing schools, but it has been rare indeed for any one school to admit that it is the one that should be discontinued. We have tended to resent state regulatory measures and have loudly condemned some of the rather arbitrary practices of the inspecting authority, without admitting even to curselves the more fundamental problem of oversupply with which the state authorities are confronted. We are now faced with cold facts and statistics, however. They can neither be denied nor explained away by those who will think matters through.

A Nurse Gives Her Views

Some hospitals have even gone further than was advised by the regulatory bodies in improving the standards of their schools of nursing. A study in one well known school in New York State indicates that 60 per cent of the student nurses' time is devoted to education and that only 40 per cent is devoted to nursing hospital patients. Such a course can scarcely be said to exploit the student nurse. The very fact, however, of improvement in their nursing education has put the same hospitals in a difficult situation at the present time, because they are finding it almost impossible to obtain funds for defraying the mounting costs of nursing education.

Good schools are seriously concerned about their inability to find employment for their graduates. The time is probably near when economic necessity will cause discontinuance of many schools which must depend for support upon hospital funds alone. Should unemployment of graduate nurses continue to the extent that hospital nurses may be hired for $55 or $60 a month, as is true at present in the metropolitan district, will not many hospitals, seeking ways to economize, find a graduate nursing staff to be definitely cheaper than a high grade school?

One of the nurse members of this committee has made the following statement in connection with the financing of nursing education:

"A school of nursing is an educational activity, and should be financed from monies collected for educational purposes.

"The tradition of financing such schools from hospital funds, that is, funds collected for the care of the sick, is an abuse of such funds and was established when the cost of educating the nurse was slight and the service to the hospital great. The hospital could then justify this use of such funds.

"Until hospitals decide what proportion of their funds should be set aside for nursing care, not much progress can be made. If, however, this can become a known quantity, then everything spent over this amount, spent because the hospital is conducting a school of nursing, should be taken from educational funds which have been either especially collected or set aside for that purpose. Such additional expense for education should not be included in the cost of caring for the sick, nor should it be included in any overhead that affects the rates for patients. If the hospital wishes to make the contribution of conducting a school of nursing, that is its privilege and pleasure, but it should not raise the patient cost per day in order to do so. In other words, the sick patient should not be asked to support this purely educational activity."

The logic of this statement is hardly debatable. The facts of the statement will have to be faced with increasing frequency as the cost of nursing education increases, and especially if there is a concurrent decrease in the cost of employing graduate personnel. It is likely, therefore, that in the future hospital superintendents will join nurse educators in studying the possible methods for financing schools of nursing. Despite the statement, usually unfair, that the superintendent wants a school of nursing merely because it is a cheap and convenient means of nursing sick patients, this committee believes that many hospital superintendents and their boards of trustees are sincerely interested in their schools as educational institutions and, therefore, as definite community assets. When those who control the destinies of hospitals find as some have already done that the hospital *per se* cannot support this educational activity, they will look about for ways and means of getting subsidies for nursing education.

Relieving the Hospital of Expense

It is not a new idea that public funds might well be employed in the teaching of nursing. It is conceivable that properly regulated nursing schools might logically be supported and assisted, as they are now inspected and regulated, by the state department of education. A member of this committee has investigated how this might be effected and has been advised that while special laws and budgetary allowances would be required, such a plan is not necessarily impossible.

Some schools have already partially solved this problem by charging high tuition fees, using these fees to cover the cost of those purely educational factors which it is not proper to charge to sick patients. Other schools are fortunate enough to possess endowments the income from which is definitely allocated to nursing education. In other instances public educational institutions have taken over the teaching of the didactic courses of the

curriculum, thus relieving the nursing schools and hospitals of much expense. There are probably other means of transferring educational costs to agencies other than the hospital itself, and it is believed that all sensible efforts in this direction should be encouraged.

As previously indicated, a pressing problem with the members of the nursing profession today is how to keep employed. As soon as the profession generally realizes the extent of overproduction of nurses, one of its principal objectives will be to decrease the number of nurses graduated.

Problems of the Small Schools

The nurse educator in these days has almost unlimited material from which to choose her students. If she is conscientious, however, she is wondering whether her school should accept large classes now just because good material is readily obtainable, or whether the school should look to the future of these students and accept only as many as may have hope of future employment. If the school accepts a full complement or more of the excellent candidates who apply, must it also feel responsible for placing these nurses in positions when they graduate? There are those who argue that few professional schools guarantee employment to their graduates and that the budding engineer, the physician or the lawyer must himself accept the responsibility for finding future employment, the professional schools holding themselves responsible only for providing a high grade of instruction.

It may also be argued that it is not exploitation to educate nurses, even though there is no certainty of their future employment, upon the basis that the future is not now bright for students in any profession or trade. The latter argument seems weak, however, in that even if economic conditions were good, there would still be too many nurses.

It has long been the belief of one member of this committee that group thinking of doctors, hospital administrators and nurses can perhaps do a great deal toward solving some of these nursing problems, but that in the last analysis the situation will be more vitally influenced by powerful economic forces which are bound to supervene. It is beyond belief that young women will continue to embrace the profession of nursing if that profession offers them less opportunity than they find in other lines of endeavor.

In studying the nursing situation, this committee finds a definite feeling upon the part of some of the small schools that the grading committee's recommendations and the trend generally in handling the nursing problem would tend to condemn the small schools, merely because they are small. The small school naturally feels that such a deduction would be unsound.

One administrator points to the fine work of the Frontier Nursing Service in the Kentucky mountains. These nurses, who travel miles on horseback to reach their patients and whose training in midwifery, for instance, has prompted the state health officer to give them special licenses to attend normal deliveries, whose services, in short, are indispensable to that community, are all trained in hospitals of from fifteen to forty bed capacity. This seems to this administrator to be a fine evidence of the fact that a hospital training school may fit its education of nurses to the peculiar needs of its own community and he deplores any thought of a plan that would educate a nurse in a large city hospital with the expectation that she would be either capable or willing to meet the nursing requirements of a frontier community.

The small schools also advance the thought that the school curriculum advised by the state department of education at Albany, N. Y., without, so far as they know, any direct counsel with the small schools is failing to fit the needs of their schools and could probably be improved were there more frequent consultation between state officials and the schools in their field.

The small schools also express bewilderment, if not irritation, at the difficulty they have in obtaining teachers for their schools of nursing who meet the approval of the state inspecting authorities. One superintendent says: "Did you ever have to try to get some help from Albany in your quest for the proper teacher?" The committee believes that this is often a real problem for certain schools and that if the necessary regulatory work of the state department of education could be tempered with more facilities for constructive assistance with problems of this nature, the general situation would be improved.

The Committee Recommends—

Let it be said, however, that while past proceedings of the Hospital Association of the State of New York indicate numerous points of disagreement between the hospital field and the state department of education, nevertheless the work this department has accomplished in the elevation of nursing and indirectly in the improvement of hospital work generally is not to be denied. Though the hospitals may insist upon their right to be heard in the formulation of the nursing policies of this department, their general attitude should surely be that of endorsement of a job which, in the main, is being well done.

While this problem, as a whole like many others,

will largely be decided by economic forces, this committee has concurred in a series of recommendations which if followed should tend to bring the desired changes more quickly.

These recommendations are:

1. That immediate action be taken to control overproduction of nurses through omission by schools of one of the two preliminary classes accepted each year until such time as the problem may have become less acute.

2. That schools now unable to maintain proper educational standards close, or make their standards acceptable by securing funds through endowments, public subsidies, or private gifts; increase the fees for tuition sufficiently to meet increased financial demands, or decrease the size of the school, if that will result in better education of the individual.

3. That when possible two or more schools in the same community establish central arrangements for instruction whenever this would increase educational advantages, or decrease the expense or both.

4. That every hospital board and superintendent, in conscientious conference with the officials of their school of nursing, consider whether the continuance of the school is justified, and if found not justified, discontinue the school as promptly as possible.

5. That schools take no direct responsibility for placement of their graduates, but that continued inability of graduates to obtain employment be considered as a strong point in favor of discontinuance or reduced enrollment of a school.

6. That all concerned not only agree that the nursing school should be a purely educational project, but that they act in accordance with that belief in connection with the operation of their own schools.

7. That the delegates of the Hospital Association of New York State who act in an advisory capacity to the state board of nursing education be instructed to inform that body that the association recommends a review of the nursing curriculum with the needs of the smaller schools in mind; that it believes assistance should be given, particularly to smaller schools, in securing approved staff members; that approval or disapproval of schools in small or remote communities should be based partially upon the effect of such approval or disapproval upon the community.

8. That all concerned resolve to study each problem involving nursing education, with an open mind and with a realization that these problems will eventually be solved by economic forces, if they are not sooner solved by intelligent action in the field itself.

Are Hospitals to Be Projected Into a Price War?

"Are we to face in the hospital field a spectacle of price cutting such as we have witnessed in gasoline wars?" asks R. G. Walker, credit manager, California Hospital, Los Angeles, in an article in *Western Hospital Review*.

Mr. Walker presents the two basic principles underlying the theory of price cutting as follows: (1) to procure more volume of business and thereby more profit—or less loss; (2) to pass on to the public benefits of economies actually accomplished by improved internal management or market savings. It is the first principle that is now foremost in the hospital executive's mind.

He sets up a theoretical example of price cutting in the hospital and its effect on the problem. A $160,000 annual income from 20,000 patient days averages $8 a patient day. A reduction of 10 per cent—or $16,000—requires 2,222 patient days' increased business to recover the loss from the price cut—or 11.11 per cent of increased business.

If a price war comes and all hospitals cut their rates 10 per cent, the reduction will not benefit the entire group, Mr. Walker holds, but on the contrary will result in further reduced incomes for all.

Keep the Prices at Present Levels

"In commercial competition," he maintains, "price wars are generally pushed by large, financially solid organizations with the goal in mind of driving out, through economic failure, the less stable competitor and later raising prices to recover losses and reap profit. I know of no such spirit in the hospital field and of no institution or group of institutions capable of effecting this policy of strangulation."

Mr. Walker offers a suggestion: "Let us keep our prices at present levels and require those who can pay the full price to do so. Let us convert our de luxe rooms when necessary into wards or semi-private rooms. Let us take our staff doctors into our confidence and invite them to bring us some of their worthy cases at prices they can afford to pay. This is our new business.

"Truly, business exists for all of us and can be procured without a price war which would defeat our purpose. Where is it? It exists in the same clientele we have always had—the patients of our staff doctors.

"Then when the depression passes, we shall find the necessity for part pay growing less and less. When that time arrives, no problem of raising prices will confront us."

How This Teaching Out-Patient Unit Is Aiding Physicians

By W. E. CARTER, M.D.
Director, Out-Patient Department, University of California Hospital, San Francisco

THE idea of aiding in the care of patients of moderate financial resources by offering the practitioners of medicine the help of a well equipped and well staffed institution is now to the fore.

The out-patient department of the University of California Hospital, San Francisco, seeks to provide such a service to the physicians of California. It accepts patients when recommended by practitioners. When hospitalization is needed, arrangements must be made in advance. Indeed, already more than 1,000 doctors in various parts of the state have taken advantage of the clinic's resources at various times. Physicians have sought aid particularly for those patients whose physical and mental disorders have been obscure. The clinic's staff has studied those patients with the aid of its extensive facilities, and has returned them to the doctor with full reports of findings in each case.

The dean of the University of California Medical School has stated recently that the university holds it to be part of its function as a state teaching institution to assist the practitioners of the state in every way possible. It is expected that this service will be a help to postgraduate instruction, as well as a clinical aid and a service to the sick.

The clinic welcomes information from physicians about any patient who comes to the department, and it holds such information confidential. The clinic makes no charge for medical service. It charges only a clinic cost rate for laboratory procedures and supplies to those who are entitled to the advantage.

Many Come From Distant Districts

Cheapened automobile transportation makes possible the referring of an increasing number of the sick from districts distant from San Francisco Bay. The department supplies a list of inexpensive rooms near the hospital where patients may lodge during the course of their stay in the clinic. Practitioners are asked to accompany their patients when possible, and to aid in studying them.

As further assistance to physicians, the department sends, on request, through the medical school library, a packet containing the latest literature relative to the patient's malady.

The reasons for this attempt to aid practitioners are perhaps self-evident. Of the persons one sees in any mixed group, it is a conservative estimate that half need medical attention for one reason or another; but it is certain that no such proportion are getting adequate care.

Barriers to Adequate Care

Attempting to overcome their ills, sick persons often mistakenly resort to various measures:

1. They take patent medicines. The fact that the annual sale of proprietaries in the United States runs into hundreds of millions of dollars is evidence of the magnitude of this practice.

2. They patronize cultists. A recent survey indicated that a large group of people regard doctors as of two kinds; the one, the cultists, whom they call when they suffer from persistent discomfort or ordinary illnesses; the other, trained medical men whom they summon when acutely or seriously ill. The number of practicing cultists who thrive is further evidence that the public lacks knowledge about medical science and too often is misled.

3. They indulge in home remedies. The use of amulets, herb teas and poultices, which they hear about and purchase and which physicians so often see employed, would be amusing were they not often followed by tragic consequences.

4. They use methods of dieting, often grotesque in character, which they hear of, or read about—column on column of misinformation.

5. They exercise the trait of "pollyannaism," and in the face of mild illness, they do nothing; meanwhile their cancers become incurable, their hypertensions irreducible, their kidney degenerations unarrestable, their mild goiters toxic, their middle ear processes necrotic.

Patients of limited financial means who go to well ordered clinics are telling their more fortunately placed neighbors (and even their employers) how complete a modern medical service can be. Many of these friends heretofore have contented themselves with faith healing, or back rub-

bing or, indeed, with hastily written prescriptions; those who attend clinics are arousing in their friends a desire for a more searching medical service. The proof that this is true lies in the fact that an increasing number of such neighbors and employers are applying to out-patient departments and health centers. These applicants would be many more were it not for the thorough questioning to which they are subjected during the process of their social service examination. The desire to be treated in an out-patient department is by no means always based on financial need. Frequently someone comes into any large clinic, and says, "I want a complete examination here, and I can pay a reasonable sum for it."

Educational Value Is Great

It is apparent that the educational value to the public of work done in modern health centers and out-patient departments of teaching institutions is an actual stimulus, encouraging people to support practicing physicians. As these institutions increase in number and quality, a greater amount of medical work will accrue to those general practitioners who are prepared to give efficient medical care. It is plain that the profession must recognize this need, and must organize the means through which these demands may be met.

Throughout the current discussion of the many suggestions made for improving the care of the sick, it is interesting to notice that almost every writer regards the general practitioner of medicine, the family physician, as the backbone of every plan proposed. It is agreed that the responsibility and effort must inevitably fall on him. In the past, he has received scant support. The public has expected miracles of him; but often it has been unwilling, or unable to pay for the most important x-ray or clinical laboratory procedures necessary for him to do good work.

Every man engaged in general practice knows that scarcely a day goes by, but he must do without some essential clinical laboratory procedure or some needed x-ray work. These omissions leave him without information, short of important knowledge, merely because the patient cannot afford the means of developing it. The result is something damaging, not only to the patient but also often to the physician's reputation as a practitioner. Indeed he may be humiliated to find that one of his poorer class patients has gone to a clinic, received a thorough examination with the consequent discovery of some condition which had been unrecognized before, because of a lack of certain diagnostic procedures. We hope that these difficulties may be relieved through the cooperation of our institution.

Hospital Problems From Three Points of View

THE CRISIS IN HOSPITAL FINANCE, by Michael M. Davis and C. Rufus Rorem, The University of Chicago Press.

Contemporary problems in hospital finance and ways of meeting them are discussed by the authors of this book from the points of view of the public, the physician and the hospital. The basic facts underlying the issues and the experimentation leading to their solution are presented. Many of the studies included have been previously published but several chapters are entirely new and into most of the other chapters new material has been incorporated.

The decrease of paying patients, and the increase of nonpaying patients, fewer gifts from philanthropic donors and the curtailment of community funds have combined to bring many hospitals to the verge of bankruptcy and to endanger public health in the opinion of the two economists. To make an appreciable improvement in hospital finance in the United States, the authors point out, would require the raising of about $2,000,000,000 of endowment funds, or more than four times the present amount and more than twice the endowment of all the colleges and universities in the United States.

Tax funds and sickness insurance are suggested as two ways of meeting hospital expenses. It is stated that approximately 400 different business enterprises in the United States have established more or less complete medical services for their employees, taking care of approximately 2,000,000 workers in this way. Many other miscellaneous groups have formed insurance associations, often by direct agreement with a local hospital.

Many explanatory tables and charts clarify the text matter and the collection of these separate studies and their republication in book form is to be commended at this time when many pressing issues demanding action confront trustees, administrators, physicians and others concerned with hospitals.

Out-Patient Department Established by Ohio Hospital

The People's Hospital, Akron, Ohio, has announced the establishment of an out-patient department, the gift of Mr. and Mrs. Stanley H. Austin, in memory of their son. R. E. Kepler has been appointed superintendent of the hospital and Dr. Edward L. Voke, New York City, will be the radiologist.

A Hospital That Serves as a Center of Negro Medical Education

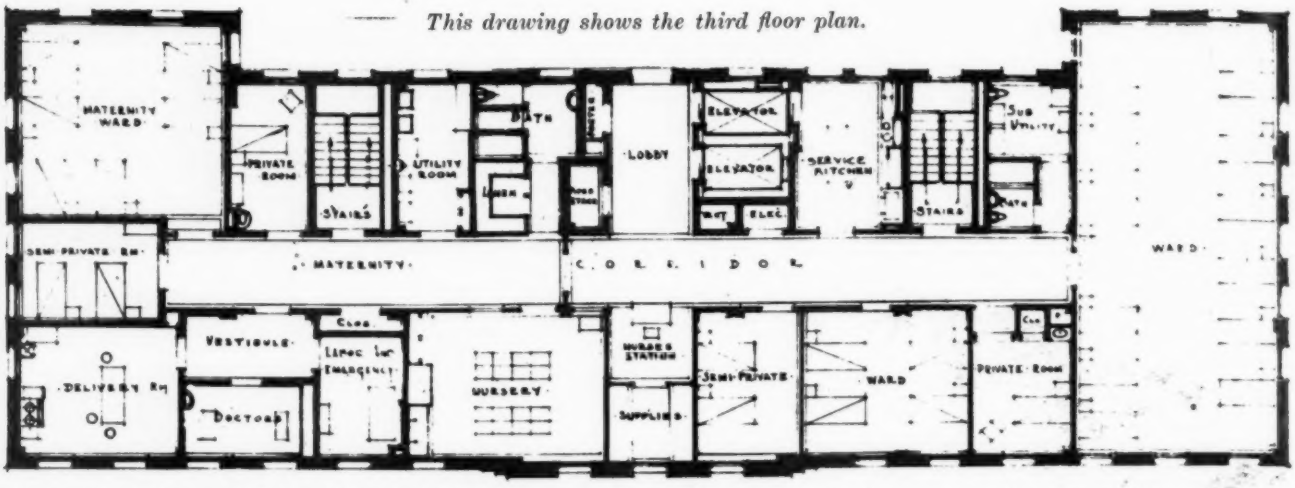
By MOISE H. GOLDSTEIN
Architect, New Orleans, and
B. C. MacLEAN, M.D.
Superintendent, Touro Infirmary, New Orleans

THE possibilities of racial cooperation in the development of educational institutions below the Mason and Dixon's line are not fully appreciated or understood by Americans generally. Of particular interest, therefore, was a successful campaign for funds, held in New Orleans in 1930 for the founding of Dillard University and to combine the activities of three Negro institutions—New Orleans University, Straight College and the old Flint Goodridge Hospital. The new Flint Goodridge Hospital is the first completed unit.

Of the $2,000,000 fund raised, $1,750,000 was contributed by such foundations as the General Education Board, the American Missionary Association, the Board of Education of the Methodist Episcopal Church and the Julius Rosenwald Fund. The remaining $250,000 was raised by popular subscription among white and colored citizens of New Orleans and included a donation from the city itself.

The old Flint Goodridge Hospital had bravely attempted to serve the needs of the colored people of New Orleans for many years but was greatly handicapped by having inadequate space, equipment and facilities. The new Flint Goodridge Hospital which was opened February 1, 1932, occupies an entire city square in the heart of the Negro residential section of the city and consists of a main hospital building with capacity for 100 beds, a nurses' home accommodating fifty-two in residence, and a separate laundry building. These three buildings are placed around a central landscaped court and the mechanical plant is designed and arranged for the possible addition of a future medical college on the open side of the court, although a survey made by the Rosenwald Fund has

This drawing shows the third floor plan.



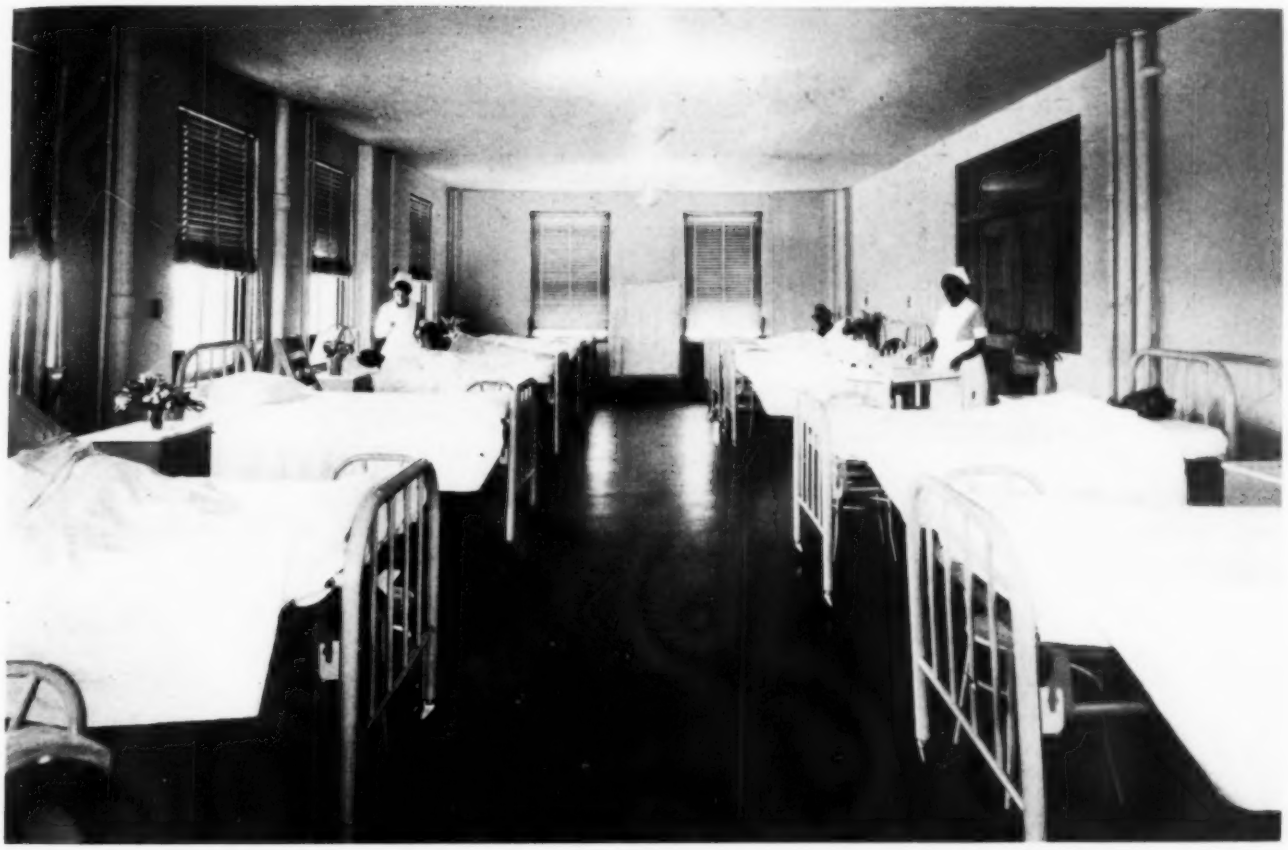
shown that there will in all probability be no need for such a development within the near future.

The hospital is so designed that a wing can be added at the rear for bed accommodation only, materially increasing the bed capacity without there being need for additional service facilities, as the utility rooms, elevator service and general services would articulate with this addition.

The building is fireproof and the exterior facing is principally in brick with some features of limestone. The sun terrace at the second floor level has a tile floor. In the halls terrazzo is used for the floors, with a protective base of the same material. The floors of the operating suite also are of terrazzo with walls of dove gray tile. In the wards and rooms the floors are of composition asbestos tile and in the service pantries of ceramic tile. The ceilings of pantries and the nursery ceiling are treated with acoustical tile.

The office and record room are so arranged as to provide for a unit system of records accessible to and serving both the indoor service and out-patient clinic. The laboratory on the second floor is in a vertical line with the operating department on the fourth floor, the delivery rooms on the third floor, the out-patient department on the first floor and the autopsy room in the basement. It is so arranged that all these departments are connected with it by a special dumb-waiter. The autopsy room has special ventilation equipment and there

A corner of the out-patient department waiting room in the new Flint Goodridge Hospital.



The large wards are virtually enclosed sleeping porches, having three exposures with a window on the fourth side also.

is also an apparatus for treating and purifying the air.

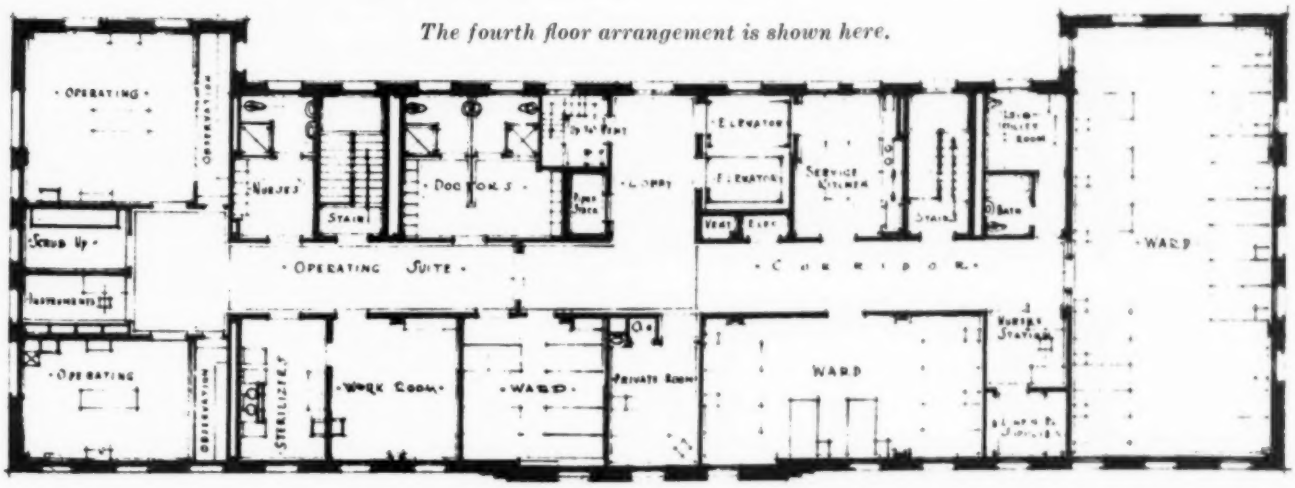
Another special feature is the arrangement of the x-ray department which adjoins the laboratory on the second floor with access directly from the main hospital corridor and a separate access from the out-patient clinic so that it may serve both, although a separation of out-patients from hospital patients may still be maintained.

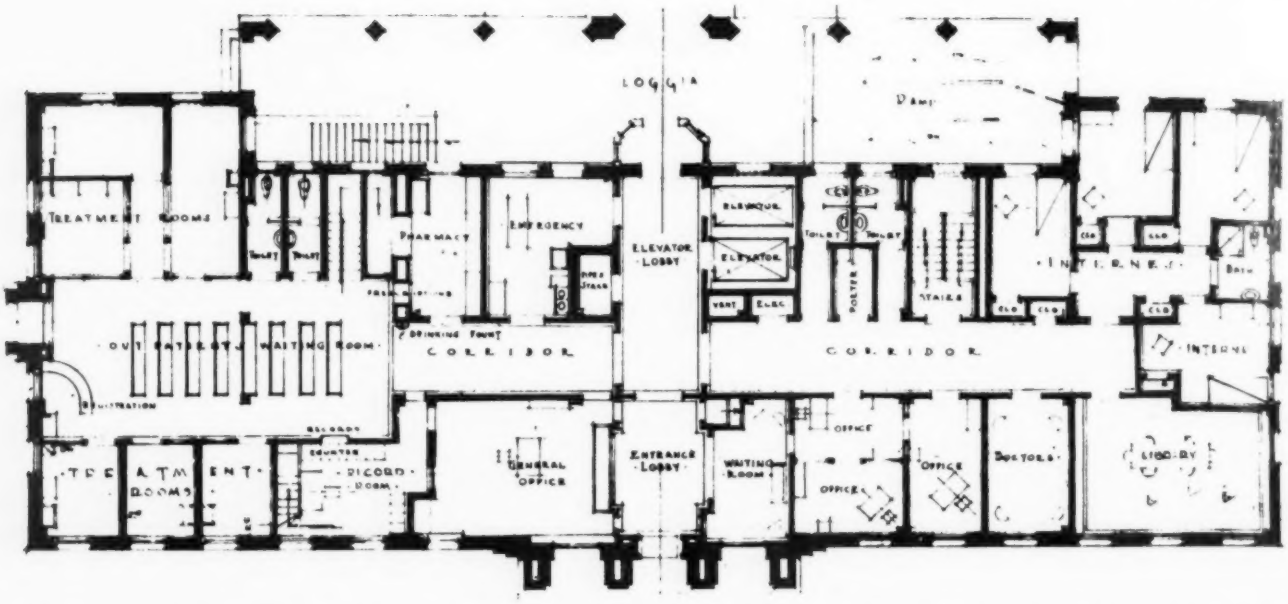
The large wards have three exposures with a window on the fourth side also. They are virtually enclosed sleeping porches. These wards accommodate sixteen patients and there are smaller wards for four and six patients in addition to three two-bed rooms and four single or private rooms.

There are two elevators, one of which is for emergency use and for service. This elevator deposits the food trucks in the serving pantries.

There is a three-run ramp which permits the bringing in of large supplies and ice directly to the receiving department in the basement, at a common point of entrance with such products as are received directly from the service elevator. The pantry arrangement and kitchen services are all kept under single supervision, including refrigerators which are cooled by central refrigeration.

The fourth floor arrangement is shown here.





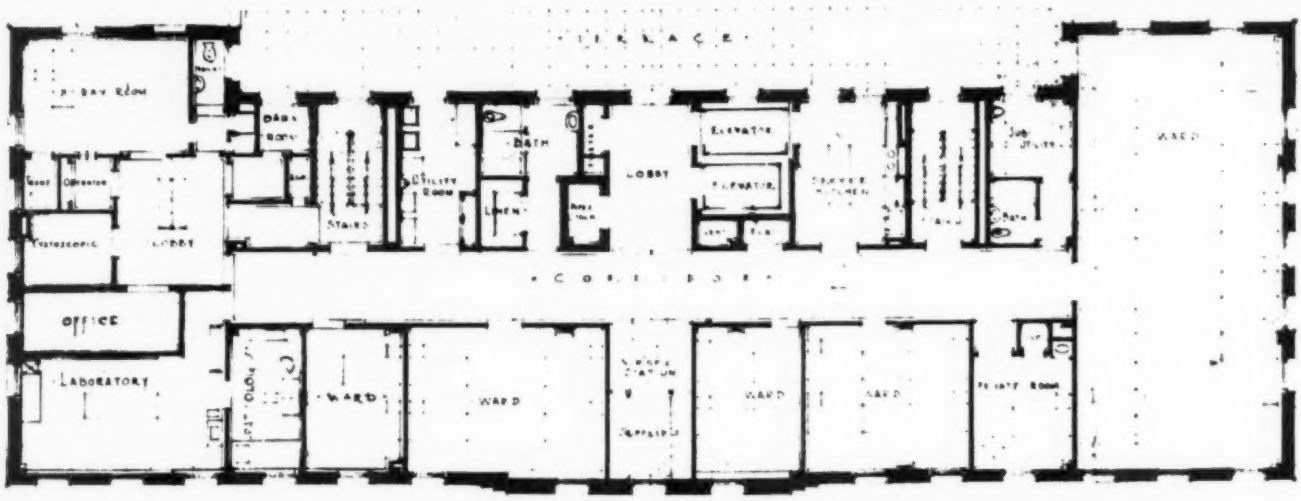
The operating suite includes two operating rooms, each of which has an observation platform constructed of tile and with a separate entrance to the corridor. This department by a rearrangement of the present workroom may be expanded to provide another operating room. The interns in residence are accommodated on the first floor in a suite off the main corridor. The equipment throughout is of the highest quality requiring the minimum of maintenance and replacement. There is indirect lighting in all rooms and wards and all beds are provided with wired conduits for a radio.

The corridors above the base are painted in two tones of emerald green, with a dark dividing strip, and all rooms and wards are of a warmer tone, with the exception of the nursery and the maternity ward which are treated individually in color. In the nurses' home are a large living room, with a bay window and casement sash, a fireplace, with bright Mexican tile, and a smaller reception room. There is also a library furnished informally with comfortable chairs and a central table and two adjoining classrooms which can be made into one. A demonstration room and the other usual facilities are provided, including a kitchenette and a small laundry on each of the two floors.

The cost of the buildings was $293,600; of the equipment, $68,900, making a total cost of $362,500. The cubic foot cost of the hospital building was $0.58, excluding equipment but including all plumbing and the mechanical and refrigerating plant.

Dr. Michael Davis, director of medical services, the Julius Rosenwald Fund, Dr. N. E. Davis, of the Board of Hospitals, Homes and Deaconess Work, of the Methodist Episcopal Church, and the superintendent of Touro Infirmary assisted the architect and have consulted with the management in matters of administration.

The problem of staff organization presented



The drawing at the top of the page illustrates the arrangement of the first floor of the Flint Goodridge Hospital, while the plan at the bottom shows the design of the second floor.

many difficulties. A hospital of 100 beds obviously could not meet the hospital needs of 120,000 Negroes, but it could serve as a center of Negro medical education and this was its primary purpose—the training of Negro physicians, interns, nurses, dietitians and social workers. Only a few of the Negro practicing physicians had had the advantage of postgraduate hospital training and even these were not prepared to conduct teaching clinics or direct clinical services such as are required in a modern hospital.

A medical advisory committee of five white New Orleans physicians, one of whom is superintendent of a New Orleans hospital, was chosen to assist in planning the staff organization. It was realized that the successful launching of a Negro teaching hospital would require the assistance of white physicians of experience, and it was also believed that it would be impossible during the first year or two to allocate to the colored physicians a definite staff status other than "associate." The only exception to this arrangement is in the surgical service where a competent colored physician was appointed as chief of service with a prominent white surgeon as consultant.

Seven divisions of service were established (1) medicine; (2) surgery; (3) gynecology and obstetrics; (4) urology; (5) pediatrics; (6) otolaryngology; (7) ophthalmology. The ultimate plan of staff organization provides for the following gradation in each service—chief, senior associate, junior associate, clinical assistant. In the meantime the responsibilty for the direction of each service rests upon a white consulting staff, which consists of a senior and a junior consultant. The senior consultants are outstanding physicians and teachers of long experience. The junior consultants are younger men of marked ability whose training and aptitude make them particularly fitted for teaching in the clinics and wards.

The main entrance to the Flint Goodridge Hospital, New Orleans.

The associate staff consists of thirty-three colored physicians who will eventually constitute the active staff of the hospital. Every colored physician in New Orleans was offered the privilege of

attaching himself to one of the services and ninety-five per cent of these doctors declared their willingness to do so and are working in the out-patient clinics and wards under the supervision of the consulting staff. Twenty per cent of the beds are for charity work and all applicants for admission to these wards or to the out-patient clinics are investigated by a social worker.

The resident staff consists of five interns, seven nursing supervisors, thirty-nine student nurses, a dietitian and a social worker. The superintendent is a capable young layman who possesses the tact that is so necessary in such a position and whose previous training as an executive in other fields fitted him well for this position. The director of nurses not only has had experience in conducting a training school but through a traveling fellowship has visited many of the larger hospitals of the United States. The engagement of colored personnel throughout is in line with the aim and purpose of the institution.

Difficulties of staff operation were inevitable but these have proved to be no greater than are experienced in any new hospital where no racial factors are involved.

Any fear of exploitation on the part of the Negro physicians seems to have been dispelled by a cooperative attitude on the part of the junior and senior consultants and by the assistance rendered the new institution by the superintendent and heads of all departments of another New Orleans hospital. Altogether the hospital affords an example of racial cooperation that augurs well for Negro education in the South.

Better Nursing at Night Is a Cardinal Need in the Hospital

A new deal for the hospital patient at night is asked by Blanche Pfefferkorn, R.N., after a study of the night nursing service in seven hospitals on the eastern seaboard. Miss Pfefferkorn's analysis of the nursing on acute medical and surgical wards in these hospitals forms the basis of a striking article in the *American Journal of Nursing's* November issue.

"While from the standpoint of the student there is much that is difficult to defend in the present system of night nursing, from the standpoint of the patient there is more that is indefensible," states Miss Pfefferkorn, who is director of studies of the National League of Nursing Education. "The wise innovations introduced in the last two decades into the nursing program by day—graduate head nurses, an increased number of bedside graduate nurses, more and better supervision, shorter hours, and supplementary ward workers—have scarcely touched the night nursing program."

To get the data presented in her article, Miss Pfefferkorn obtained permission from the hospitals to spend twelve consecutive hours from 7 p.m. to 7 a.m. observing nursing at night. The information thus obtained was treated as strictly confidential. Once the material was gathered it was indexed under a code. The interest of the National League of Nursing Education is not in the nursing in any particular hospital, but in nursing at large. Further, it is believed that the nursing conditions found in the seven hospitals visited are not peculiar to these institutions but that similar conditions exist in many other hospitals.

In six of the seven institutions visited, the acute medical and surgical wards studied were staffed with student nurses. In the other a graduate and a student constituted the bedside staff throughout the night. The average number of minutes of care per patient in these hospitals ranged all the way from 21.8 to 144 minutes.

Quality of Service Varies

Not only was there a wide range in the quantity of service, but there was an equally wide range in the quality of service, Miss Pfefferkorn found. In three of the hospitals visited, the night nursing on the wards where observations were made was entirely delegated to students who had been in school less than a year. In these three hospitals, ten or twelve-hour duty was still in effect. Inadequate preparation and long hours of service both militated seriously against the safe care of the patient, Miss Pfefferkorn contends.

Not only was the nursing of patients delegated to an inadequate and immature staff, but the study indicated that night supervisors are not selected upon the same high standards as are the day supervisors. Two instances of excellent night supervision were cited. Certain other improvements were noted, such as the postponement of the early morning work until 5 or 6 a.m., and the serving of breakfasts by the day staff instead of the hurried unsatisfactory serving by the night nurse.

If patients are to have proper care at night, four conditions must obtain, Miss Pfefferkorn concludes. These are as follows:

1. Enough nursing time must be provided.
2. Night nurses must be adequately prepared. This provision includes a liberal number of graduate bedside nurses for the night.
3. Enough supervision must be provided, both in quality and in quantity.
4. A reasonable hour schedule must be put into effect.

Preventive Mental Medicine and How to Promote It

By WILLIAM A. BRYAN, M.D.
Superintendent, Worcester State Hospital, Worcester, Mass.

MENTAL disease is the most important public health problem that confronts the world today. It is important from the economic point of view, and it is still more important from the humanitarian standpoint.

The average daily population of the mental hospitals in the United States is 395,407 as against an average population of 331,359 in all other types of hospitals. The average percentage of occupied beds in mental hospitals is 95.4. The daily average of mental patients increased by 26,372 between 1928 and 1929, compared with a decrease of 5,793 of all other hospital patients. There is a daily average of 324.6 persons per 100,000 population in mental hospitals and an average of only 192.1 in general hospitals. These statistics, quoted from the *Journal of the American Medical Association*, give some indication of the size of the problem.

The mental hospital, like every other hospital, has changed to a marked degree during the past two decades. Specialization has divided among the many the work that was formerly carried on by a few. All hospital organizations have increased in complexity and in expense. Does the increased expense justify itself in greater efficiency, the criterion of efficiency being the discharge of patients back into the community? Are the mental hospitals of today, with their highly organized staffs, discharging more patients? Are they keeping discharged patients out of the hospital longer? Are they shortening the hospital time of the individual patient? Unless these questions can be answered in the affirmative, it is questionable if the increased cost of modern mental hospital administration is justified.

State Hospital Must Take Lead

The mental hospital as an exclusive therapeutic agency is in my opinion rapidly coming to an end. The modern state hospital must be prepared to accept the full responsibility for the mental health of the community it serves. It must be the fountainhead to which the people of the community will turn for guidance in their mental health problems, whether they are questions of delinquency, mental disorder or borderline states. In any adequate program of mental hygiene, therefore, the state hospital must play a prominent rôle. And why not? Millions of dollars are spent on equipment and personnel. Why set up new institutions and organizations to carry on this work when we already have going concerns?

The Road to Progress

But the mental hospital must prepare itself to meet the demands that will be made upon it. It must recognize the responsibilities it faces and be alert to build up proper organizations to meet these responsibilities. In discussing the best way by which these responsibilities may be met, I propose to suggest five ways by which the mental hospital can place itself in a better position to serve the community and to do constructive work in the prevention of mental disease.

As I see the situation, the real functions of the mental hospital are psychiatry, medicine and surgery, teaching, research and community activity.

Better psychiatry would mean that representatives of every school of psychiatric thought would be welcome on the staff of the mental hospital. I feel sure that the secrets of human behavior will never be found by working exclusively from one point of approach. We shall be able to discharge our full duty to the patient and to society only by pooling the studies made by many persons of widely diversified points of view. There is room for everyone in this problem, but in such an organization it is essential that a working cooperation be maintained. Without this harmonious relationship between men of so many different points of view, there can be no real progress.

This is the problem of the administrator. The man who is so individualistic that he cannot play the game with others will never contribute much to the type of organization I am describing.

Better psychiatry would mean more than the mere labeling of the patient. It would mean more

individual study, a more careful analysis of symptoms and, above all, a more careful and systematic study of the therapeutic needs of the patient. The question of industrial therapy and occupational therapy is a case in point. We still apply occupation in a haphazard manner. If occupation is a real therapeutic procedure, then much work is needed to place it on a better and more scientific foundation. A complete reorganization of the industrial and occupational work of most hospitals is needed in order that the work may be applied for the primary purpose of benefiting the patient rather than getting the work done.

The criterion of efficiency of every member of the hospital staff should be the number of recovered patients. A man may write wonderful notes on his cases and he may spend much time and energy in studying his patients, but unless he is doing all this to get the patient home and not simply to gratify his own scientific curiosity he is not contributing much to the efficiency of the organization.

How to Change the Public Attitude

Necessarily, because of their large numbers, patients in state hospitals must be dealt with in groups. This will always be so. The expense of having a sufficient number of physicians and nurses to give complete individual attention to every patient will probably always be prohibitive, and if it were not a matter of expense the question of where such personnel, adequately trained, could be found would be a real problem.

Mental hygiene can be carried to patients exactly as it can be given to groups of normal persons. Many devices can be used to build up morale among groups of patients thus in a general way contributing to their recovery. There are psychiatrists who will take issue with me, and say that this is not psychiatry, but I am trying above all things to be as practical as possible. One of the ways to help patients directly is to change the attitude of the public towards the mental hospital, and one of the most valuable ways of doing this is to send more patients back into the community. I believe the time is rapidly approaching when the mental hospital will occupy fully as commanding a position in the community as does any hospital. The fear and ignorance of the public in regard to mental disease will be dispelled if the hospital is doing good work, and by good work I mean discharging more patients.

The relationship between the hospital and the community is an important part of the psychiatry of any mental hospital. The institution has the same problem as the manufacturer who is putting his goods before the people—first, he must have a good product, and second, he must let the world know about it. So it is with the institution. The first requisite is to have an efficient hospital where patients are being discharged into the community. The second is to bring the institution and the work it is doing to the attention of those outside. This is all a part of the psychiatric program of the mental hospital. There are those who look askance at anything that may be called advertising. Ethical publicity, however, is legitimate and worth while. The isolation of the mental hospital from the rest of the community is in no small measure due to the aloofness which has characterized psychiatrists for many decades. This isolation must be broken down before the mental hospital can take its proper place in the community.

In the organization of the mental hospital, it seems logical to suppose that proper facilities for the care and treatment of physical conditions should be provided. The relationship between the physical and the mental is not clearly defined, and a great deal of work is needed to clarify our ideas on this point. There are three reasons why a proper medical and surgical organization should be maintained in a mental hospital.

First, the care of the patient in incidental illness should be provided for, and by this care I do not mean the establishing of a few wards where patients are taken when the necessity arises. I mean a properly organized service separate from the rest of the hospital but working in cooperation with it, and having a separate personnel, the whole organization being established on the lines of the general hospital.

Just a Fallacy

In every mental hospital, there should be a general hospital of proper capacity to take care of the population of employees and patients existing within the mental hospital itself. One could hardly conceive in this day and age of a community the size of the usual state hospital which did not have adequate hospital facilities. The mental patient is not immune to the incidental illnesses and accidents that other members of the community are subject to. As a matter of fact, it has been stated that the incidence of physical disease in mental institutions is eight times that of the general population of equal number.

In reading the reports of many mental hospitals, one is struck by the place cancer occupies in the list of the causes of death. It is far down the list, and one might be tempted to believe that the patient who has mental disease has some kind

of immunity which prevents the onset of cancer. The organization and efficient management of a medical service will soon show the fallacy of this idea. Cancer is just as prevalent in the wards of a mental hospital as it is in the general community, if it is properly diagnosed. To treat mental cases adequately, medical men must be close clinical observers, since the patient gives so little assistance.

Value of a Teaching Program

The records of such a service should be separated from the general psychiatric records. They should be indexed and crossindexed in order that adequate use may be made of the statistical data. This medical department, the head of which should be one of the important officers of the hospital, should include the x-ray department, the physiotherapy room, the operating suite, the laboratory and every other group that has to do with physical illness.

The second reason for the development of a medical and surgical service in the mental hospital is the necessity for a more adequate study of the relationship between the psyche and the soma. That there is a more subtle relationship than we have heretofore been able to understand I am sure, but much work needs to be done on the wards of the mental hospital if we are to know more about this relationship. In a properly organized service, patients are sent by psychiatrists for careful study. If the personnel of this service is sufficient, it would be wise to have all physical examinations made by the medical service. I am not yet sure whether a mental hospital is a large general hospital with special facilities for the study of mental diseases, or whether it is a mental hospital with special facilities for the study of the physical.

Third, the care and treatment of employees is an important reason for the establishment of such a separate service in the mental hospital. Mental hospitals have large groups of employees and to organize their treatment properly when they are ill, in order that they may get the best service with a minimum amount of trouble on the part of the hospital, can be accomplished only in this way.

Why should a mental hospital carry the burden that comes with an extensive teaching program? There are two reasons why this particular function of a mental hospital is important. First, it is one means of solving the important problem of personnel, as it will attract intelligent newcomers into the service. It is a part of the system by which novices become master craftsmen, and it prevents the curse of all mental hospitals—institutional inertia. Teaching and being taught and keeping in touch with advanced and related fields will encourage and hold the valuable persons who form the nucleus of the hospital organization.

Second, a well worked out teaching program carried on in the new mental hospital will send into the community a great many understanding individuals who will be able to speak in authoritative terms about the hospital and the work it is doing. They will be able to carry an understanding attitude into society and thus to further the cause of mental hygiene. I do not believe that the mental hygiene of the future will be carried on by special individuals. It will be in the hands of the parent, the teacher, the physician and the nurse. In fact every member of society will have some understanding of the mental mechanisms working in himself and in those about him. Those who are constantly dealing with human beings should be thoroughly trained in an understanding of the causes that motivate human behavior.

It will probably always be necessary to have certain centers for the acquisition of further knowledge of mental processes which can be acquired only by intensive study and research and where the parent, the teacher, the physician and members of other allied professions can obtain further experience in their understanding of the human being. The training centers that are equipped with personnel are not sufficient to take care of all who need training. I believe, therefore, that the state hospital with its unlimited facilities must take a prominent part in this teaching program.

Should More Buildings Be Built?

The teaching of psychiatry can be done best by actual case work. It is impossible to learn much about human beings from books or lectures. It is essential that everyone be brought into actual contact with patients. To this end, the teaching program should not consist of isolated groups coming to the hospital for lectures, but courses should be arranged for a sufficient period to give the student an adequate understanding of the mental mechanisms through contact with patients. Medical students should receive at least three months' training in the wards of the mental hospital during their fourth year of school. Undergraduate nurses in general hospitals should spend a part of their training period in mental work. Theological students, occupational therapists, social workers and many other groups should be affiliated with a mental hospital and should be given a thorough, carefully organized course of

training while actually working with the patients.

Mental disease is the one branch of medicine that has always been in the hands of the state. The problem is so great and so important that it has always seemed wise to let the state assume the burden, since it is the only agency that is large and powerful enough to give adequate care and proper treatment to the victims of these disorders. For many years, states have willingly carried this great economic burden. They have tried to meet the problem by constantly erecting more buildings and putting in more beds to house more patients. Few states have succeeded in catching up with their building programs. As soon as new buildings have been built, the population has increased, and the hospital has become as crowded as it was before. It seems to me that the time has arrived to look over the future building programs carefully and see if there is not a better way of meeting this great problem.

Research Is Needed

Would not a more intelligent way of handling the situation be to make an effort to attack the problem at its source? Would it not be worth while to set aside some of the millions going into new buildings each year for the purpose of organizing a systematic and orderly research program to determine the cause of some of these mental conditions? One of the greatest needs in psychiatry today is fundamental research into the etiology of such diseases as dementia praecox. We know little about the real cause of mental disease, and yet we go on increasing our facilities for housing mental patients without spending anything to find out what it is all about. Research in general paresis has raised the remission rate from approximately 4 to 40 per cent, and what has been done in general paresis may be done in other types of disease.

An industrial organization that had a problem like this would spend many millions of dollars to find the cause. I believe that a great deal of progress will be made in relieving society of a great economic burden if a program of research in mental diseases is inaugurated, with sufficient money to carry it on for a reasonable number of years.

One of the reasons why so little has been accomplished in research into the cause of mental disorder is that research has never been made an important and integral part of the policy of a state. Legislatures have been thinking in terms of increasing facilities, and the lack of proper guidance in this matter on the part of hospital administrators has probably kept their minds concentrated on this one approach.

A second reason is that sufficient money has never been appropriated for a long enough time to accomplish any adequate result. Most of the research into mental disorders has been carried on by philanthropic individuals, and most of the conclusions at which we have arrived have been based upon work done on small groups of patients. The state hospital must organize itself to carry on an adequate research program. We cannot hope to make progress in our treatment until better methods of evaluating that treatment are evolved.

The community work of a mental hospital is of two kinds, first, the establishment of clinics for the prevention and extramural treatment of mental disease and second the education of the public. The prevention of mental disease is as important a responsibility of the mental hospital as the care and treatment of patients. If child guidance clinics are to make any real dent in the situation as it exists today, they will have to be greatly increased both in number and in size.

The establishment of a clinic in the community is a highly specialized work. It is not sufficient that a member of the hospital staff be sent out at intervals to serve the community in this way, although if better means are not available, this is preferable to doing nothing. Every mental hospital should have attached to its staff groups of persons not charged with any responsibility in the hospital but who are community workers.

Activities Must Be Broadened

Hand in hand with this program comes the dissemination of information and educational propaganda. It is true that few fundamental principles have been worked out in mental hygiene, but a few things that we know should be constantly spread abroad in order that they may become a part of the mental equipment of as many persons in the community as can be reached. Legitimate publicity in regard to the work of the hospital and mental hygiene in general is an essential part of the program of every mental institution. Public lectures, radio talks and newspaper publicity are all valuable and useful in getting society to the point where it will be able to overcome the superstition that is still so prevalent about mental conditions.

The state hospital of the future will prepare itself to broaden the field of its activity in many ways. This is the day of preventive medicine and the profession is thinking in terms of both prevention and cure. The state hospital system, with its elaborate physical plants and large personnel, is the logical place to carry on a program of prevention and research, organized on a sufficiently extensive scale to throw some light upon the etiology of the different types of the psychoses.

Convalescent Home Is an Asset to the Community

By DOROTHY PRIWER, M.S.
and
B. Y. GLASSBERG, M.D.
Departments of Social Work and Medicine, Washington University, St. Louis

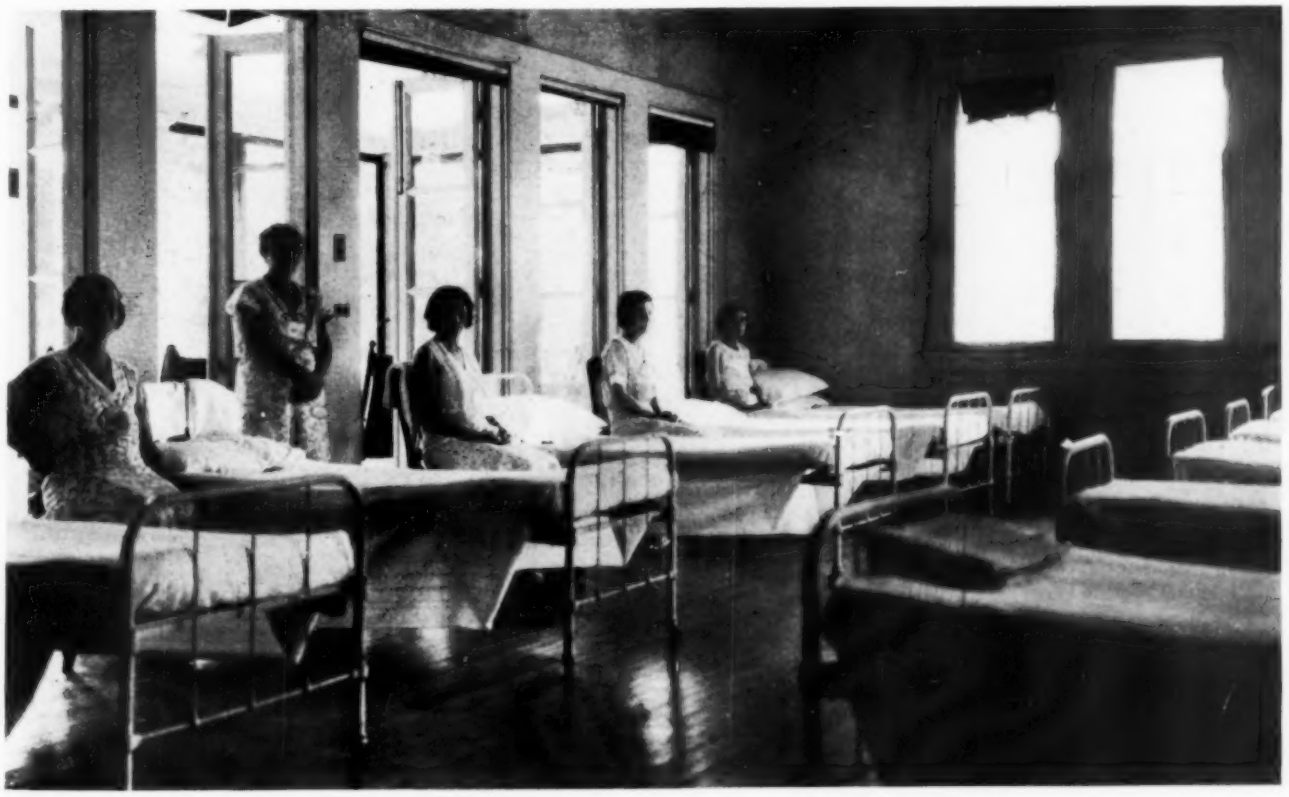
THE recognition and acceptance of a period of convalescence as a definite phase of physical illness, during which the individual's normal health is reestablished, is rather recent. Not until the beginning of the twentieth century was convalescent care acknowledged as an integral part of medical care and treatment.

Dr. Haven Emerson, New York City, recently estimated that a city the size of St. Louis should have at least 500 convalescent beds. Miriam Convalescent Home, Webster Groves, Mo., just about five miles from St. Louis, provides the only convalescent facilities in the vicinity of St. Louis. The institution contains thirty beds and these are not used to capacity throughout the year.

This convalescent home was opened in 1913 through the efforts of a group of women of the Miriam Lodge. It shortly became nonsectarian, accepting patients without regard to religious affiliation. It conformed to the accepted standards for such institutions. The home was dedicated to the rehabilitation of the economically dependent who were not able to resume their places in the community immediately after a hospital stay.

The system of record keeping at Miriam Convalescent Home was revised in 1929, and in the fall of 1931 the records covering the two-year period were made available for study.[1] An attempt was made in this study to evaluate convalescent care given patients who had stayed in the institu-

[1]The study was used as material for a Master's thesis by Dorothy Priwer, Washington University, St. Louis.



A section of the women's dormitory, showing the entrance to the connecting sun porch.

TABLE II—ONE HUNDRED PATIENTS CLASSIFIED BY CHANGE OF WEIGHT AT TIME OF FOLLOW-UP AND ESTIMATE OF THE PATIENT'S ABILITY TO WORK OUTSIDE OF THE HOME, IN THE HOME, OR TO ATTEND SCHOOL AT TIME OF FOLLOW-UP

Change in Weight at Follow-up	*No. of Patients*	*Ability to Work at Time of Follow-up*								
		Outside of Home			*In the Home*			*To Attend School*		
		Greater	*Same*	*Less*	*Greater*	*Same*	*Less*	*Greater*	*Same*	*Less*
Greater than at discharge	53	12	8	1	9	18	2	3		
Equal to weight at discharge	7	1		1	2	2			1	
Less than at discharge, but more than at admission	18	3	3		5	4	3			
Equal to weight at admission	7	2	2			2			1	
Less than at admission	15	4	1	3	1	5	1			
Total	100	22	14	5	17	31	6	3	2	

tion for a period of ten days or more between September, 1929, and September, 1931. Only those who were recovering from an organic condition were included in the study, patients diagnosed as neurotic or psychotic being excluded.

The criteria used to judge the benefit of a stay in the home are as follows: (1) Increase in weight while at Miriam Convalescent Home and the maintaining of this gain after discharge; (2) the reestablishment of the individual's normal health as shown by physical reexamination, and (3) the degree of social rehabilitation shown by the patient at the time of discharge and at the time of the follow-up interview, as evidenced by the patient's statement as to whether or not he was able to resume his usual occupation.

During the two-year period, 605 patients were admitted to Miriam Convalescent Home. Only 144 of these patients had received convalescent care for an organic condition and had remained as convalescent patients for ten days or more. One hundred of these cases were selected for study.

Of the 100 patients studied, about one-half were married, and therefore had definite social responsibilities. About three-fourths of them were between the ages of twenty and fifty, which is usually considered the socially productive period of life. Ninety-eight of the patients studied were admitted to Miriam Convalescent Home after having been seen by a social worker in one of the St. Louis agencies. Eighty of the one hundred patients studied were referred to the home from the in-patient or the out-patient departments of seven local medical institutions. Depending upon the

TABLE I—ONE HUNDRED PATIENTS CLASSIFIED BY DIAGNOSTIC GROUPS AND BY CHANGE IN WEIGHT BETWEEN ADMISSION TO AND DISCHARGE FROM MIRIAM CONVALESCENT HOME

Change in Weight in Pounds	*No. of Patients*	*Patients Classified by Diagnostic Groups*				
		Post-surgical	*Malnutrition*	*Cardiovascular-Renal*	*Respiratory*	*Miscellaneous*
Loss						
Less than 1 lb.	3	2		1		
Less than 2 lbs.	1					1
Less than 3 lbs.	5		2	2	1	
Stationary						
Gain						
Less than 1 lb.	1					1
1 lb.	13	5	2	3		3
2 lbs.	14	3	3	2	2	4
3 lbs.	16	5	4	2	2	3
4 lbs.	6	2	1		1	2
5 lbs.	6	1		1	1	3
6 lbs.	8	4	2	1	1	
7 lbs.	8	1	4	1	2	
8 lbs.	3	2				1
9 lbs.	4	1			1	2
10 lbs.	1			1		
11 lbs. and over	8	2		1	2	3
Therapeutic loss	3	1		1		1
Total	100	29	18	16	13	24

Groups of malnourished children spend part of the summer at the home and enjoy this playground.

agency report, each patient paid from nothing to $9 a week, although the average weekly cost to the home is about $15 a patient. The diagnostic classifications employed are indicated in the accompanying tables, except for the group included under miscellaneous, which is composed of such diverse clinical entities as typhus fever, endocrine disorders, pelvic cellulitis, gastric ulcer, postencephalitic residual and muscle atrophy.

Table I indicates that the greatest gain in weight takes place in the respiratory group and the smallest gain in the cardiovascular-renal group, with the average median gain in weight of all patients being 4.3 pounds. Of greater significance is the fact that the maximum improvement observed generally takes place within forty-four days, which is entirely in accord with our usual clinical findings. There was no noticeable difference in improvement, as measured by change in weight, between those patients who received care in the in-patient department or the out-patient department of an acute hospital before admission to the convalescent home.

Table II indicates a direct relationship between the gain in weight at the time of the follow-up, made from two to twenty-four months after dis-

TABLE III—ONE HUNDRED PATIENTS CLASSIFIED BY CHANGE IN WEIGHT AT TIME OF FOLLOW-UP AND BY PHYSICIAN'S ESTIMATE OF PHYSICAL CONDITION AT TIME OF FOLLOW-UP

Change in Weight at Follow-up	*No. of Patients*	*Physician's Estimate of Functional Impairment*			
		None	*Slight*	*Moderate*	*Great*
Greater than at discharge	53	28	18	7	
Equal to weight at discharge	7	2	3	2	
Less than at discharge, but more than at admission	18	10	5	3	
Equal to weight at admission	7	4	2	1	
Less than at admission	15	6	5	3	1
Total	100	50	33	16	1

TABLE IV—ONE HUNDRED PATIENTS CLASSIFIED ACCORDING TO DIAGNOSTIC GROUPS AND PHYSICIAN'S OPINION OF FUNCTIONAL IMPAIRMENT AT TIME OF FOLLOW-UP

Diagnostic Groups	*No. of Patients*	*Physician's Opinion of Functional Impairment at Time of Follow-up*			
		None	*Slight*	*Moderate*	*Great*
Postsurgical	29	15	10	4	
Malnutrition	18	12	4	2	
Cardiovascular-renal	16	5	6	4	1
Respiratory	13	9	3	1	
Miscellaneous	24	9	10	5[1]	
Total	100	50	33	16	1

[1]These five patients were diagnosed as follows: one postencephalitic, one draining infection of the arm and three arthritics.

charge, and the patient's ability to resume a place of potential social usefulness at the time of the follow-up. Apparently the gain in weight is associated with a less easily measured increase in the vital capacity of the patient.

Significance of Gain in Weight

Table III shows an inverse relation between the gain in weight and functional impairment; that is, the greater gain in weight is associated with lessened functional impairment. In the consideration of this table it must be remembered that those patients in whom an increase in functional ability was not anticipated, for example, the advanced cardiovascular-renal group and the chronic arthritics, were not omitted from the tabulation. Similar conclusions may be drawn from Table IV and Table V.

The objective evidence presented in the various tables leads to the inevitable conclusion that convalescent care does have considerable value in the economic rehabilitation of the recovering sick. However, it should not be necessary to prove the usefulness of convalescent care as its value is fully recognized in the treatment of the wealthy. Its economic saving to the community is easily established, yet too often the sick poor are sent home and sent to work as soon as they are able to walk. When we realize the benefit of convalescent care, it is a source of consternation to know that the good facilities offered at Miriam Convalescent Home are not always used to capacity.

Certain constructive criticism arose during the course of the study that was designed to increase the usefulness of the institution. It was pointed out that too often an attempt is made to use the home as a "dumping ground." It was also made clear that a large summer population is dependent chiefly upon the admission of patients who, from the community standpoint, are not in need of convalescent care. The study showed that patient day costs could be reduced considerably below two dollars if there were greater year round occupancy. It was further revealed that an institution of this type offers a partial answer to the patient day cost of six dollars or more found in the average private hospital.

Modern hospital and clinic management assigns important duties to the social worker. The Miriam Convalescent Home has tried to follow this principle, but workers in medical and nonmedical institutions have failed to cooperate with the home. The social workers were requested to fill in blank spaces on a card, mailed by the convalescent home six weeks after the patient's discharge, in order that the home might secure information as to the functional gain made by the patient. In only thirty-four cases, about one-third of the total, did the social worker send the complete information to the home.

Discharged Patients Must Be Watched

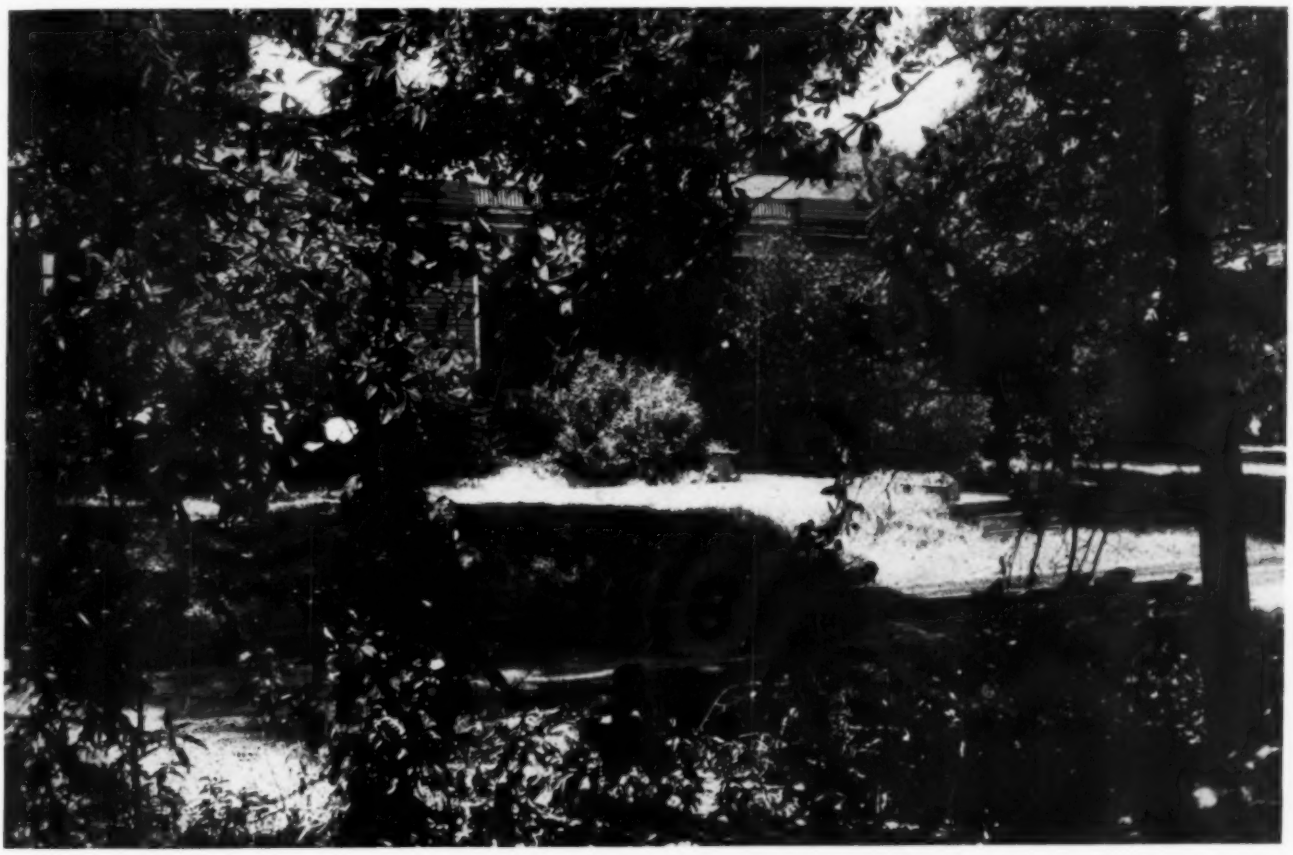
The social worker should make it possible for the patient to receive convalescent care as part of a complete plan for the restoration of health. Her duty, broadly interpreted, is to adjust home factors that stand in the way of attaining this goal. Furthermore, since many borderline neurotics

TABLE V—ONE HUNDRED PATIENTS CLASSIFIED BY CHANGE IN WEIGHT AT TIME OF FOLLOW-UP AND BY PHYSICIAN'S ESTIMATE OF PHYSICAL CONDITION AT TIME OF FOLLOW-UP

Change in Weight at Follow-up	*No. of Patients*	*Physician's Estimate of Physical Condition at Time of Follow-up as Compared With Time of Admission*		
		Improved	*Unimproved*	*Retrogressed*
Greater than at discharge	53	43	10	
Equal to weight at discharge	7	5	2	
Less than at discharge, but more than at admission	18	17	1	
Equal to weight at admission	7	4	2	1
Less than at admission	15	11	4	
Total	100	80	19	1

apply for admission to the home, it was felt that the addition of a trained social worker whose duty it would be to adjust the patient to his environment, might prove valuable. A trained worker on the staff of the institution, it was felt, would tend to diminish the number of repeaters, those patients who find intermittent residency desirable in order to build anew the fortitude necessary to cope with their normal squalid environment.

Evidence of indifference on the part of discharged patients in retaining their improved health was revealed by the study. A number of the patients referred to the home suffer from more



One of the main buildings at the Miriam Convalescent Home, surrounded by trees and shrubs.

or less chronic illnesses, such as cardiovascular-renal and gastric conditions. The benefit resulting from a stay at the convalescent home may be quickly dissipated if the patient fails to visit his physician at regular intervals after discharge. This is another situation where the social worker should function. She should see that the patient receives proper care after discharge from the convalescent institution so that full benefit of his stay in the home may be realized by the patient.

The following examples illustrate the need for proper follow-up activities:

Charles L—, age nineteen, was referred to the home on account of heart disease secondary to mitral valve disease. A stay of fifty-eight days, with adequate diet, graded exercise and digitalis brought about a remarkable improvement. At discharge he weighed fourteen pounds more than at the time of admission. The sole supporter of four persons, he worked at odd jobs until the time of the follow-up interview eight months after his discharge from the convalescent home. At this interview it was discovered that he not only had lost all of the weight gained during his stay at the home, but that he weighed two pounds less than he had at the time of entry. Since his discharge he had not seen a physician and no social worker had invited him to return to the referring clinic for examination. As might be expected, the cardiac condition had become aggravated and it is entirely reasonable to expect that this lad will shortly require another period of hospital care at the expense of the community.

Ida R—, age thirty-one, was referred to the home on account of a gastric ulcer. During a thirty-two-day stay under adequate dietary supervision she gained four pounds and became entirely symptom free. A widow and the sole support of one child, she found employment as a housemaid. During the fifteen months between her discharge from the home and the follow-up interview she gained an additional four and a half pounds, but she had not been seen by a physician. It is coincidental

that during the three or four weeks preceding the follow-up interview, a recurrence of the old symptoms induced her to undergo partial starvation in a voluntary effort at cure. One wonders why she did not immediately seek medical attention, yet she was mildly surprised when told that the clinic that had originally referred her to the home would probably be glad to give her advice regarding the new symptoms.

What the Study Revealed

It must be remembered that the patient applying for aid and for convalescent care usually is relatively unintelligent. Just as the community has provided free convalescent care for him, just so it is to the advantage of the community to ensure his continuous attendance at that clinic if it would reap the fullest dollar value out of the money already expended. It is the duty of the community and the community agencies to ensure the continued well-being of the discharged patient in order that he may continue economically useful in the community.

The following conclusions have been reached as a result of the study that was made of this group of 100 patients:

1. The Miriam Convalescent Home restored to working ability equal to or greater than before illness eighty-nine of the 100 patients, thus demonstrating the value of scientific care for those convalescing from a serious illness.

2. While it is authoritatively stated that a city as large as that served by this home should have a minimum of 500 convalescent beds, the thirty beds already available in the community are less than half occupied except during two months of summer. It is to be hoped that the failure to utilize these facilities completely may be remedied by dissemination of knowledge concerning the institution and its work.

3. The effective service of such an institution may be considerably enhanced by the provision of a social worker who will aid in the rehabilitation of the repeater patient who is constantly demanding aid and attention, yet fails to profit from them for more than a few months at a time because of indifference on his part.

4. The effectiveness of such an institution may be furthered by a closer liaison between the social worker responsible for the patient and the referring medical agency. Continued, regular insistence by the social worker that the diseased, though not necessarily ill patient return to the clinic for examination should be considered an integral part of convalescent care. Provision for such follow-up will greatly increase the dollar value of the convalescent home to the community.

Three Fallacies That Interfere With Good Management

Three fallacies that have come to be associated with hospitals and hospital management are discussed by R. H. P. Orde, secretary, British Hospitals Association, in a recent issue of *The Hospital*.

These fallacies, as listed by Mr. Orde, are: (1) Plead poverty; (2) business management cannot be applied to hospitals; (3) that the hospital has no right to protect itself from being imposed on—either by accident cases or by patients able to pay.

"There are committees of management of hospitals who accept it as an administrative axiom that the end of each year should show a debit balance—that a bank overdraft is, if not the best form of appeal, at any rate a good claim to sympathy and support. Such is not the case. Business men and corporations are impressed by businesslike methods. A credit balance for the hospital at the end of the year will appeal more to the modern public than an adverse balance ever did to the old."

Have Right to Sue for Payment

Mr. Orde insists that business management can be applied to hospitals. "Those methods of common sense and logic which have been followed in all other successful activities are as applicable to hospitals as they are to shipping, banking or coal mining. It is no exaggeration to say that 95 per cent of the expenditure of a hospital responds to those methods of control that have been proved in the commercial world."

Concerning the right of hospitals to sue for payments that are justly owing them from patients who can pay, Mr. Orde says: "At the outset hospitals were founded for a quite clear and specific purpose—to relieve the sickness and suffering of the poor. Since the poor could not pay, there was no object whatever in committees of management of hospitals possessing the power to charge their patients or to sue them for the recovery of money spent on their treatment. One does not sue to recover a gift, and besides it is no good suing persons who have nothing.

"Today, a hospital, while it still treats the poor for nothing, still keeps its doors open for accidents, has developed and extended both purpose and scope until there is not a single institutional health function it does not in some shape or other perform. Because the hospital of 1750 did not require the power to sue, there is no reason to assume that the hospital of 1932 is doing anything disgraceful in protecting itself from imposition by any means in its power, legal or otherwise. We must stand up for ourselves and make use of all the legitimate means in our power to obtain our dues."

How the Depression Affected New York State Hospitals in 1930

By CLARENCE E. FORD
Assistant Commissioner, New York State Department of Social Welfare, Albany, N. Y.

THE New York State board of social welfare supervises all public hospitals other than those for mental diseases and such private hospitals as are in receipt of public funds for the support of patients.

On June 30, 1931, the close of the fiscal year covered by this report, there were under supervision 79 public hospitals, 229 private hospitals and 5 miscellaneous medical institutions.

As a basis for discussion a few tables are presented herewith which have been prepared from data submitted by the hospitals for the calendar year 1930. The first table divides the hospitals into five groups according to function and separates the public and private hospitals in each group. Information is given as to the number of hospitals, the number of beds, the average number of patients and the extent to which the beds are used.

Both the calendar year covered by these statistics and the fiscal year of the report were considered to be periods of extreme business depression, but examination of the statistics given in the tables indicates that this depression had little effect on hospital operations. The percentage of occupancy of the private general hospitals was practically the same as in 1929, as was also the average length of stay of each patient. Statistics show also that in 1930, 10 per cent of the patients in the private general hospitals were cared for free and that these patients received 11 per cent of the total number of days' care, items that correspond exactly with those for the preceding year. There has been, however, some increase in the number of patients cared for in public hospitals and these institutions show a high percentage of occupancy. An increase in the per capita per diem cost of

TABLE I—DATA RELATIVE TO 292 HOSPITALS IN NEW YORK STATE FOR THE YEAR 1930

	Number	*Beds Including Bassinets*	*Average Number of Patients*	*Per Cent of Utilization*
General:				
Public	30	12,622	10,535	85
Private	178	26,044	17,346	67
Tuberculosis:				
Public	34	4,909	4,411	90
Private	10	1,857	1,646	89
Contagious:				
Public	10	1,439	767	53
Private	1	32	16	50
Orthopedic:				
Public	1	120	120	100
Private	6	966	786	94
Other Special:				
Public	1	250	247	99
Private	21	3,680	2,502	68
Total public	76	19,340	16,084	83
Total private	216	32,579	22,296	68
Grand total	292	51,919	38,380	74

TABLE II—THE AVERAGE NUMBER OF DAYS SPENT IN HOSPITAL BY EACH PATIENT

	General	*Tuberculosis*	*Contagious*	*Orthopedic*	*Other Special*	*Totals*
Public	18.6	152.8	25.5	283.9	57.5	25.5
Private	11.6	110.8	75.1	24.2	13.1	12.8
Total	13.5	138.5	25.8	27.6	13.3	16.2

caring for patients is shown in practically every group, though this increase is most marked in the private general hospitals. With the increased cost has come greater difficulty in financing hospital operations, a condition due to a number of factors, two of which deserve particular comment.

Accident Cases Are a Burden

Ever since the passage of the Workmen's Compensation Law hospitals have complained that the rates paid for the care of injured workmen by insurance companies and self-insurers were insufficient to cover the cost of maintenance of these cases, with the result that the hospitals concerned were forced to contribute from endowment funds or voluntary contributions for the support of patients whose care should, justly, be a charge on industry.

Early in 1931 a commission was appointed by the governor of the state to study hospital problems in relation to workmen's compensation insurance. Howard Cullman, New York City, was the chairman of this commission and the department of social welfare was represented on it by Charles H. Johnson, commissioner of social welfare. Hearings have been held at which testimony has been obtained from interested groups and individuals and the commission has also met frequently for discussion of the problems involved.

In the meantime a decision of the appellate division in what is known as the Messenger Case affirms the right of hospitals to make the cost of caring for workmen's compensation cases a basis of its charge for the care of such cases. This decision has not been in force long enough so that definite conclusions can be drawn as to just how much effect it will have in obtaining for hospitals a rate of payment for compensation cases more nearly commensurate with the cost of care.

The other condition that has imposed upon hospitals a serious burden is caused by accidents not covered by the Workmen's Compensation Law. Most of these patients are automobile accident cases, injured on the public highways. Such persons frequently claim to be without funds or insist that the hospital shall look for payment to the one causing the injury, who in turn is likely to disclaim responsibility. Not infrequently after a period of months or years the injured persons obtain a substantial sum in payment of damages for injuries, but in the meantime the hospital bill has been forgotten.

In certain states laws have been passed in the last few years that give hospitals a preferential claim on compensation obtained by patients for damages sustained in accidents for which they have received treatment in such hospitals. Efforts to secure similar legislation in New York State have been made from time to time for more than fifteen years, but have thus far been unsuccessful. In the hope of obtaining exact information which would be useful in discussing this question with committees and members of the legislature, this department recently sent to the hospitals which were believed to have cared for such accident cases a questionnaire requesting information as to losses incurred from the care of automobile accident cases and also losses resulting from the care of other accident cases not coming within the Workmen's Compensation Law.

Large Amount of Hospital Construction

The data requested were for the year 1930. Replies from seventy-six hospitals were in such form as to permit of classification and indicated losses during the year mentioned. The returns showed during the year losses of about $100,000 from nonpaying accident cases and more than $50,000 from other accident cases. While the losses thus shown are doubtless a serious burden on a few hospitals they do not involve a large sum as compared with the total receipts of these hospitals and the amount of such loss in proportion to the number of hospitals is considerably less than has been shown by similar studies made elsewhere.

During the year covered by this report there was

TABLE III—THE AVERAGE PER CAPITA DAILY COST OF MAINTENANCE FOR EACH PATIENT

	General	*Tuberculosis*	*Contagious*	*Orthopedic*	*Other Special*
Public	$3.85	$3.20	$6.46	$2.62	$1.82
Private	6.50	2.00	2.95	7.94	2.49

a great amount of hospital construction due to the completion of projects under way and the erection of public hospitals, not only to provide for the care of patients but also to afford employment. Mention should be made especially of the development of the institutions of the Department of Hospitals of New York City. This department, with some 16,000 beds in its hospitals, is carrying on a hospital service unequalled in volume anywhere in the United States and possibly not equalled in any other country. While improvements were under way in practically every one of the hospitals, mention should be made particularly of the new building under construction at Kings County Hospital, Brooklyn, and of the new general hospital to serve the Borough of Queens.

Although the demands on the hospital facilities for all classes of service have been urgent, a serious situation seems to have developed because of the lack of provision for the care of patients suffering from tuberculosis. Temporary buildings for this purpose have been provided at Sea View Hospital, Staten Island, and plans are under way for the development of a new tuberculosis unit at Kings County Hospital and the construction of an infirmary at the Municipal Sanatorium, Otisville. It should be stated that there is no evidence that the increased demand for the care of tuberculous cases represents any general increase of such cases but rather that a large number of persons who are ill are under present conditions unable to support themselves.

Within the period covered by this report, dispensaries constituted the only group of institutions supervised by the department whether in receipt of public funds or not. This power is conferred by the Dispensary Law, Sections 290-296 of the State Charities Law, which gives the state board of social welfare authority to issue and revoke dispensary licenses, to visit and inspect dispensaries and to establish rules for their conduct. Since the passage of the Dispensary Law in 1899, the use of the word dispensary as a sign has been restricted to those licensed by the state board of social welfare in order to prevent misrepresentation. The legislature of 1931 placed by law the same restriction on the word clinic, which by common usage has come to mean either a subdivision of a dispensary or a small independent dispensary.

On June 30, 1931, the state board of social welfare was supervising 309 licensed dispensaries of which 94 were public and 215 under private control. During the fiscal year several dispensaries were opened and others closed but the net result was an increase of only eight in the number of public dispensaries and no increase at all in the number of private dispensaries. Statements sometimes made as to the enormous number of clinics in New York City can refer only to various social service activities and not to the distinctively medical and dental work coming within the definition of a dispensary.

TABLE IV—NUMBER OF PATIENTS AND NUMBER OF TREATMENTS IN 308 DISPENSARIES IN 1930

	Number of Patients	*Number of Treatments*
Dispensaries connected with hospitals:		
23 Public dispensaries	440,160	1,469,363
114 Private dispensaries	1,197,070	4,664,758
Total public and private	1,637,230	6,134,121
Dispensaries not connected with hospitals:		
76 Public dispensaries	136,481	387,521
95 Private dispensaries	355,483	1,228,382
Total public and private	491,964	1,615,903
Grand total	2,129,194	7,750,024

Increase in the number of dispensaries has been slow, less than 3 per cent during the year. Of the nine dispensaries licensed during the year which were not previously in operation, four were outpatient departments of hospitals while five were independent, including three for public health work and two for child welfare.

Table IV contains statistics showing the number of patients and the number of treatments in the 308 dispensaries which were in operation during 1930 or some portion of the year.

During the year a new building has been constructed at Bellevue Hospital to serve its dispensary which, on the average, treats more than a thousand patients a day and is doubtless one of the largest of its kind in the country. This improvement is the only major dispensary development during that year.

Fuel—What the Hospital Executive Should Know About It

By WILLIAM J. OVERTON
Supervising Engineer, Montefiore Hospital, New York City

PRACTICALLY all the heat on the surface of the earth is derived directly or indirectly from the sun. The heat from the sun stimulates plant life. The tremendous pressure of the earth on plant life and its decay through long periods form what is known to us as fuel, that is, coal, natural gas and fuel oil. The same physical and chemical reactions assert themselves in the earth's rock formation. The heat of the sun is naturally stored up in these fossil fuels and is artificially made available for the use of mankind.

The usual conception of heat is that it is a form of energy produced by the vibrating motion of the minute particles or molecules of a body. All bodies are composed of these molecules, which are held together by mutual cohesion and yet are in a state of continuous vibration. The hotter the body or the more heat added to it, the more vigorous is the vibration of the molecules.

Many classifications of the grades of coal have been made on the basis of their different properties. The classification most commonly known to the layman, however, is as follows: anthracite, semianthracite, bituminous, semibituminous, subbituminous and lignite.

Anthracite is the best of all coals for steaming purposes. It is practically all carbon and is relatively clean, but is difficult to ignite. It burns slowly with comparatively little smoke. It has deservedly earned the common name of "hard coal" from its firm substance. It has high heating value, often liberating over 14,000 B.T.U. per pound of fuel when burned in air. It contains a very small percentage of volatile constituents and a hotter flame results from its combustion.

It is marketed in the following screened sizes:

	Inches
Broken	3½ to 4½
Egg	2 5/16 to 3¼
Stove	1⅝ to 2 5/16
Chestnut	⅞ to 1⅝
Pea	9/16 to ⅞
No. 1 buckwheat	5/16 to 9/16
No. 2 buckwheat or rice	3/16 to 5/16
No. 3 buckwheat or barley	3/32 to 3/16
Culm	3/32

The larger sizes of anthracite are rarely used for commercial steam generating purposes, as the demand for domestic use now limits its supply. In commercial plants the sizes generally found are No. 1, No. 2 and No. 3 buckwheat. In some plants culm is burned in combination with bituminous coal in certain ratios, such as a two to one mixture, by which the best results both in economy and capacity are obtained. Semianthracite burns more rapidly than anthracite coal. It burns with a relatively short flame, but with a longer flame than that produced by anthracite. This is because the percentage of volatile constituents is higher in the semianthracite coal. It leaves but few clinkers and burns with little smoke. It is sometimes designated as hard coal.

How to Get Bids on Coal

In this country bituminous coal is by far the most common. Because of the variations in the percentages of volatile matter, some bituminous coal burns freely with a short flame, while other varieties burn with a longer flame. Some are difficult to burn without considerable smoke, and larger clinkers are usually formed. Highly volatile coals are generally used for manufacturing illuminating gas, as the mechanical stoker equipment has not yet been perfected that will burn this type of coal economically and efficiently. The heat value of bituminous coal varies from below 11,000 to over 14,000 B.T.U. per pound. There is no classification of bituminous coal as to size that holds true in all localities. Grading of Western bituminous coal differs from that of the Eastern coal. The American Society of Mechanical Engineers suggests the following grading:

1. Run of mine coal: the unscreened coal as taken from the mine.

2. Lump coal: that which passes over a bar screen 1¼ inches wide.

3. Nut coal: that which passes through a bar screen with 1¼-inch openings and over one with ¾-inch openings.

4. Slack coal: that which passes through a bar screen with ¾-inch openings.

Some bituminous coal is similar to anthracite in appearance, possessing a high heating value

with little moisture and a low percentage of ash. It burns with little smoke. The coal is much softer than the so-called hard coals and is excellent for steaming purposes, but because of the limited supply, only small quantities of it are used. The medium by which the quantity of heat is measured is known as the British thermal unit (B.T.U.). While until recently this has ordinarily been defined as the amount of heat necessary to raise the temperature of one pound of water at a definite temperature 1° F., the value generally accepted is 1/180 of the amount of heat required to raise one pound of pure water from ice point (32° F.) to the steam point (212° F.), both at standard pressure, or a mechanical equivalent of one B.T.U. equaling 778 foot pounds.

When purchasing the aforementioned coals, it is necessary to know their content. This can be determined only by a responsible chemist. A proximate analysis of fuel reports the percentage by weight of moisture, fixed carbon, ash, volatile matter, B.T.U. and sulphur. To obtain the sample for the chemist's analysis (presuming that a size of coal has been selected to suit the type of grates and stoker), when delivery is made to the bunker, a pile containing about 200 pounds should be taken and thoroughly mixed by coning and reconing until only two samples are kept to fill two quart containers. These should be sealed airtight and forwarded to the laboratory. It is not good practice to allow the sample that is to be tested to stand in an open vessel for any length of time, as some of the moisture will evaporate and the result will be an incorrect analysis.

In specifying the grade of coal to be used, the following procedure is recommended: (1) Bidding should be done strictly on a competitive basis; (2) the field should be broadened for both bidder and purchaser; (3) if coal other than that specified is substituted there should be a penalty clause to protect the purchaser; (4) if the coal is uniformly poorer than the standard specified, there should be a basis for cancellation, the coal to be hauled away at no cost to the purchaser.

The following information should be requested on the bid sheet:

Moisture	Freight rate
Volatile	Name of railroad to be shipped over
Sulphur	Cost per gross or net ton at mine
Ash	Cost per gross or net ton trimmed at bunkers
Fusion point	Cost of boating, if any
B.T.U.	Cost of trucking, if any
Point of shipment	Name of seam
Name of mine owner	
If coal is purchased from a jobber, state mine	
Name of county and state where mined	

"If there should be any difference between our scale weights and the railroad's bill of lading, the adjustment should not exceed more than 1 per cent."

With the aid of a buyer's guide, the purchaser will have little difficulty in determining whether or not he is receiving the coal he orders, as he has found out the location, the seam and mine and the names of the county, mine operator and railroad and can check against the bidder. When he receives the analysis made after the coal has been delivered, he has the whole story before him, practically from the mine to the furnace. Careful consideration should be given beforehand to the different phases of the coal problem. For instance, if the specifications call for a coal with 7 per cent ash, and the shipper has delivered a coal that proves on analysis to have 10 per cent ash, this would mean that 3 per cent of ash has been paid for in freight, only to be assigned later to the ash pile.

The total number of B.T.U.'s should conform as closely as possible to specifications, allowing a few degrees one way or the other for discrepancies in the analysis.

The volatile content should be given serious thought, as some of the higher volatile coals, although economical to use, cause a smoke nuisance, which is a violation of local health ordinances in some sections. If fuel has been used and the evaporation of water per pound of fuel falls below the known quantity, everything else being equal, it is an indication that some other coal has been substituted and an investigation should be instituted at once.

Storage Is Important Factor

The grade of coal is an important point, as some stokers when burning bituminous coal require a coking quality and some a noncoking quality. The size may play an important part in both efficiency and cost. If a smaller size coal can be advantageously consumed, it can be purchased at a lower figure. This holds true with anthracite. Some specifications should include the fusion temperature that may be required, as this is a measure to determine clinkering, especially when bituminous coal is burned with anthracite. The bituminous coal should have a high fusion point and should be of a coking quality so that the anthracite is not released, but fused in with the bituminous, both being consumed at the same time. Anthracite may for all purposes carry a certain percentage of rock, slate or bone, according to the size of the coal. A piece of coal containing scarcely any carbon is classed as rock. One with less than 40 per cent carbon is slate. One with over 65 per cent carbon is classed as coal. These coals must be free from mud or discoloration.

A considerable amount of slate and rock with not so much bone will make the coal pile look dull instead of fairly bright. Care should be taken to

have the specifications call for the percentage of slate, rock or bone in coal. The high percentage of this foreign matter causes excessive clinkering, not only running up the cost of the fuel per ton but also ruining the furnace brickwork, because of the adhesion of clinkers.

The storage of coal is an important factor because of the influence of certain conditions, such as the risk of labor difficulties, the distance of the consumer from the mine and transportation facilities. As anthracite is not subject to spontaneous combustion, this fuel is ideal to store in unlimited amounts in one pile. Bituminous coal cannot be stored this way, as spontaneous combustion may take place in a short time. An important feature is the initial temperature of coal at the time of storage. It should be handled during the coolest part of the day, since the heat is absorbed at this time and liberated at night. Unless there is some logical reason for the storage of coal in large quantities, it is best to keep as little of it on hand as practicable. The storage place should of course be chosen with reference to convenience and the ease of transferring the fuel from the bunkers to the furnace. Labor, like coal, represents money and it is often more difficult to handle than the inanimate fuel.

Care should be taken in the selection of the coal and ash handling equipment. A chemical change, generally in the interior, manifests itself in the storage pile. Two changes may take place in the coal, first, the oxidation of the inorganic matter, such as pyrites, whereby there is a marked increase in volume, sometimes an increase in weight and obvious disintegration, and second, the oxidation of the organic matter of the actual coal. This cannot be detected by the naked eye, but leads to the loss of heating value, through the oxidation of hydrogen and carbon and the absorption of oxygen by the unsaturated hydrocarbon.

Watch Out for Air Leakage

Most engineers regard combustion as a baffling problem. There is absolutely no mystery about fire and water. We bring the two together and the result is steam. There is no more mystery about a furnace and a boiler than there is about a stove and a kettle. The process in each case is exactly the same. It consists in getting the heat out of the fuel and into the water. There are accordingly two general questions in the economical production of steam: (1) Are you deriving the full benefit from your fuel? (2) Are you putting as much as possible of the heat generated into the boiler?

All the coal that is bought should be burned economically and efficiently and all the heat from the coal that is burned should be used. Considerable heat may be lost up the smokestack or through the furnace walls. The boiler settings should be examined for air leaks or porous bricks, loose mortar joints or any air leakage into the furnace. After the source of these leaks is discovered repairs should be made immediately.

The composition of coal varies over such a wide range and the methods of firing have to be altered so greatly to suit the various coals and the innumerable types of furnaces in which they are burned that any instructions given for the handling of different fuels must of necessity be general. For each kind of coal, there is some method of firing that will give the best results for each set of conditions. General rules can be suggested, but the best results will be obtained only by following methods that are expedient and practicable and best suited to the specific conditions.

Three Types of Fuel Oil

Before combustion can occur, the temperature of the fuel must be raised to the ignition point. Thus the temperature at which the heat is liberated by the union of the fuel with oxygen is evolved faster than it is conducted away. Then the fuel becomes hotter, and the union proceeds more rapidly. This in turn heats the fuel and the immediate surroundings faster, until flame occurs. After the ignition temperature is once obtained, the combustion will proceed automatically. Oxygen, which is necessary for combustion for burning fuel, is usually obtained from the air and may be forced through the fuel bed by mechanical means or natural stack drafts. Atmospheric air is a mechanical mixture of oxygen and nitrogen and other gases, the latter two not being combustible. When oxygen meets carbon, hydrogen, sulphur or other combustibles in the presence of heat, chemical union occurs and what is known as combustion takes place and heat results. A solution of the draft problem may lie in the consideration of the following significant factors: the quantity of the draft in relation to carbon dioxide; the amount of heat allowed to escape up the smokestack; the fuel bed thickness; proper regulation of the boiler damper; proper size and grade of the fuel to be consumed with the type of stoker and furnace in use.

The most modern conception of fuel economy and efficiency comes in the form of pulverized coal. However, it has been used only in central and industrial power plants. It cannot be advantageously applied to some already established institutional plants, as the type of boiler setting in an old installation is not adaptable to the change.

Fuel oil is the only liquid fuel sufficiently abundant for steam generation. While geologists are not in entire agreement as to the origin of petro-

leum, that is, whether it is of animal or vegetable matter, the generally accepted opinion is that it is of an organic nature. Crude oil, while varying widely in physical characteristics, may be broadly divided into three classes in accordance with the predominant base or the nature of the residue after distillation. These are: paraffin base, which in general includes the lighter oils; asphaltic base, which ordinarily includes the heavier grades of oils, and mixed base, which contains varying proportions of paraffin and asphaltic bases and includes the broad classes of the intermediate grade oils. When fuel oil is to be used, certain physical characteristics must be taken into consideration in the determination of the suitability of the available supply. These characteristics, together with the manner in which they affect the suitability for use in steam generation, may be summarized as follows:

The specific gravity or ratio of weight of a given volume of oil to that of an equal volume of water should be determined. The specific gravity is of importance particularly in the case of lighter oils, since it has a bearing on the calorific value. In general, the higher the specific gravity the lower the content of the lighter hydrocarbons and the lower the heat value of the oil. The specific gravity balance is determined by the pycnometer or the hydrometer. Specific gravities are generally reported at 60° F. Conversion of Baumé readings to specific gravity is necessary and it is essential that the Baumé hydrometer be accurate. This is a standard, weighted glass bulb with a graduated rod indicating the depth to which it sinks in the fluid under test. When oil is purchased on the basis of its volume at 60° F., the volume can be adjusted by using the coefficient known to the purchaser in its relation to the locality in which the oil is produced.

Flash point specifications are contingent upon viscosity requirements as well as upon general consideration for safety requirements and evaporation losses.

How to Buy Fuel Oil

Viscosity is perhaps the most important factor in determining the suitability of available fuel oils, particularly when these oils are heavy. The lighter oils have a low viscosity. Oils of the same specific gravity do not necessarily have the same viscosity. The viscosity may determine the methods of handling and pumping. In specifying for the purchase of fuel oil, the following procedures are recommended:

All purchasing should be done on a competitive basis in regard to quality and price.

The bidder should give the specific gravity, viscosity, flash point, chemical composition and heat value of the oil; the name of the oil and by what field it was produced; whether or not the oil is crude oil, a refining residuum, a distillate or a blend; fuel F.O.B. tank car, barges or tank.

Information should be supplied as to whether it contains a specific amount of water and sulphur.

It should not contain more than a trace of sand, clay or dirt.

It should be understood that the fuel oil delivered for the term of the contract be as specified. The frequent or continual failure of the contractor to deliver oil of the specified quality should be considered sufficient cause for the cancellation of the contract.

Individual conditions and requirements at the point of consumption influence to a large degree the specifications for viscosity, flash point and sulphur content.

The First Step Toward Fuel Economy

Definite specifications can be drawn for a fuel oil that will meet practically all requirements; it is therefore advisable when purchasing fuel oil that the individual requirements be studied and that as lenient specifications as possible be written to ensure the delivery of an oil that will be satisfactory for the conditions for which it was intended.

If a change is to be made from coal to fuel oil it is recommended that the furnace brick work be changed to suit the oil, but in such a manner that the stoker or grates can be used again should the price of oil increase. A comprehensive study should be given the two fuels. This does not necessarily imply a comparison of the cost of a ton of coal to a ton of oil, because oil has a far greater heating value than an equal weight of coal. While oil has a fairly high heating value, there is a tremendous difference in the heating value of different grades of coal. Therefore, when making a comparison it is necessary to know and understand the kind of coal under consideration as well as its heating value per pound.

Using oil as a fuel saves labor, as it simplifies firing. Oil fuel has many distinct advantages over coal. It is simple to handle. It eliminates the complicated mechanical stoker and its attendant labor items. It does not disintegrate or lose its calorific value when stored. The equal heat value in oil occupies comparatively much less space than coal. The cleanliness of the furnace room and engine room through the elimination of dust is an advantage. Of course, it is understood that when changing from coal to oil, an additional expense will be incurred in the purchase of the oil burning equipment and storage tanks.

There are two general classes of burners used

today in burning oil fuel—mechanical and steam atomizing burners. When atomized the oil must be brought into contact with a sufficient amount of air for combustion in a manner that assures a thorough mixture of oil and air, and at the same time the amount supplied must be kept to a minimum, controlled by the proper apparatus for introducing air into the furnace. Mechanical burners seem to be the most popular for hospital use, as they atomize the oil in such a rapid manner that ignition is more rapid than with steam atomizers and results in a shorter flame. As more than one burner is required for firing a boiler, it is quite simple for the operator to control any given load by disengaging burners as the load decreases and engaging additional burners as the load increases. The intensity of the fire can be instantly regulated to meet the fluctuating loads, ensuring a high degree of flexibility. Moreover, this fuel is so simple to control that perfect combustion is obtainable.

The first step toward fuel economy and efficiency must be taken in the fields of the fundamental sciences of chemistry, physics and mathematics, including a study of the elements of thermodynamics. In addition to a practical knowledge of the basic principles of heat transfer and air flow and the intelligent application of them in the various systems, a firm grasp must be taken of the engineering methods of attacking and analyzing these problems, not only from the point of view of scientific theory but also with due consideration of the limitations imposed by practice and by costs.

New York City Hospitals Consider Group Insurance Plan

Guaranteed hospital care for a period of three weeks may be made available to members of gainfully employed groups at a continuing expense to the individual of about what he pays for his daily paper, as a result of action taken at a meeting held at the Woman's Hospital, October 13, by the Hospital Conference of New York City, representing all the hospitals of the city.

After listening to a description by Frank Van Dyk, executive secretary, Hospital Council of Essex County, New Jersey, of the plan that has been recommended by the council to the hospitals of Essex County, the New York conference appointed a committee to study in cooperation with a committee of the United Hospital Fund the merits of group hospitalization and its feasibility for adoption in New York City.

Dr. T. Dwight Sloan, president, Hospital Conference of New York City, who presided at the meeting said that the proposed departure was a somewhat radical one but that in it might be found the solution of the problem that threatens the continued efficient hospital service of the city, already weakened by decreased gifts, inadequate support from the city and increasing demands for treatment on the part of those who can pay little or nothing. He said it was generally agreed that a new basis of support must be found to assure the future financial stability of the hospitals.

Would Establish a Common Fund

The plan as recommended to its member hospitals by the Essex County Council provides, Mr. Van Dyk said, for group participation only, of persons of both sexes between the ages of fifteen and sixty-five years, who are gainfully employed. Each individual of the group would contribute eighty-five cents a month or ten dollars a year through a pay roll deduction or as might be otherwise arranged. The employer would collect the payments and turn them over to a common hospital fund, from which the hospitals providing the service would be reimbursed. Each participating hospital would provide for these individuals, whenever necessary, a maximum of twenty-one days of care in semiprivate accommodations. The care would include board, nursing, use of the operating room, laboratory tests, x-rays, anesthetics, drugs and dressings, attention of the hospital medical staff and other hospital facilities, exclusive of physicians' or surgeons' fees. Inasmuch as the average hospital stay is less than two weeks, the three week period of free care has proved adequate. The only hospital patients not benefiting under the plan are those afflicted with chronic diseases, mental troubles, tuberculosis and contagious diseases, such as smallpox, which cannot be accepted in general hospitals. This service does not apply to patients eligible for treatment under the Workmen's Compensation Act, but it does apply in cases of accidents and other illnesses. By giving the patient semiprivate care, the physician or surgeon can keep his personal contact and can arrange his own terms for payment with his patient.

Detroit Hospital Is Given Large Sum to Buy Radium

A gift of $25,000 was recently presented to the cancer clinic of Harper Hospital, Detroit, to be used for the purchase of radium. The donor is Mrs. Hetty Speck, Grosse Pointe, Mich. A room in the clinic will be called the Speck Room.

Two Mutually Dependent Forces—The Hospital and the Doctor

By ABRAHAM OSEROFF
Director, Montefiore Hospital, Pittsburgh

"It is not the doctor against the hospital or clinic, or the hospital against the doctor—one means little or nothing without the other. They have common interests. How can both be given their just due in a comprehensive plan that will give fair consideration to the needs of the doctor, of the patient, of the hospital and of the community?"

THE physician's relation to the hospital in its present day organization has for a long time been a subject for heated discussion in exclusively medical and in hospital administrative and lay circles. The economic conditions with which all of us are now struggling intensify the demand for a clearer definition of the physician's place in the scheme of organized medical practice. It is becoming more and more urgent for us to find a definite answer to the question, "What may be expected of the physician by the hospital and the community, and what may he in return expect from the hospital and from the community?"

It would be the height of egotism for anyone to imagine that he could say the last word on this difficult subject. Dogmatic thinking is stifled thinking, and dogmatic conclusions are bound to lead us astray. In the presentation of such a subject as the one treated here, the man who claims to be certain of both his premise and his deduction, is usually the least safe to follow.

The physician, of course, does not render all the free service provided by a hospital or clinic, but without the physician free hospital work is an impossibility. The prime factor in the diagnosis, treatment or prevention of disease is the physician. As a matter of fact, the underlying purpose that motivates the creation and building of hospitals and clinics is to provide and maintain facilities that will permit the physician most effectively to serve his patients and the community in which he is located.

Going back many centuries and comparing the traditions of medicine as a profession it is apparent that medical practice in institutions is of comparatively recent development. It is not surprising, therefore, that there should have been in the past half century and that there should be even today many problems requiring solution in so complex a relationship as exists in the hospital between social worker, nurse, doctor and administrator. Rather is it more surprising that we have made as much progress as we have in so short a time.

The doctor has always been, perhaps rightly so, an individualist. In the traditional picture the doctor is seen at the patient's bedside. His prime interest is in that patient. Therefore since hospital practice and out-patient or clinic service have grown so rapidly in the past quarter century, and since there is every indication of even further increase of organized medical service along similar lines, is it any wonder that the individual medical practitioner or the doctor working with an organized medical group should think of the future with some misgiving as to his own personal welfare and the welfare of his co-workers in the profession?

Little more than fifty years ago the term "hospital" applied to the poorhouse and the pesthouse, and these words were thoroughly descriptive of the institutions, as hospitals and clinics were intended solely for the poor. Today the properly organized hospital is the health center of the community, for both curative and preventive medicine. While in a certain percentage of cases poverty may be a factor, as a general rule the patient comes to the hospital because it is the center of medical practice. Thousands of patients go to the hospital because better medical and surgical care may be obtained there than in the home or in the office of the doctor. It is an accepted fact that organized

action in the use of medical facilities rather than work by the isolated individual physician is essential to good medical practice.

Emphasis should be laid on another factor in the hospital picture which has a definite bearing on this discussion. The spotlight cannot be directed too strongly on our somewhat disjointed picture of hospitals, clinics, health centers and other medical and health organizations. Where there should be a unified, coordinated, cooperating group of organizations carrying out a clear-cut community health program, today we have institutions working largely as individual entities rather than as parts of a community scheme. Better coordination of both the hospital and the clinic facilities must be provided in various sections of the city. There must be proper integration, functionally and geographically, of the manifold medical facilities that exist in our larger cities, with their health department activities, medical work in schools, public health nursing, mental hygiene clinics and child guidance centers.

Too Much Guesswork in Building

If we are to meet the growing demand for business management of hospitals and clinics and for sane costs in the provision of medical services, we must utilize hospital plants and equipment to a greater extent than we have thus far. The building of a new hospital or a clinic, though it may be a worthy monument to the philanthropy and generosity of an individual or a group, none the less deprives existing institutions of such funds, and makes it more difficult for them to raise the necessary money for their needs. A new hospital should never be erected unless it can be clearly proved that it is built in accordance with the needs of the particular community. There has been too much of the trial and error method in hospital and clinic construction. Once such structures are built, the community must meet the bill. Hospital and clinic building must be so controlled that the plants may be fully utilized. There is little wonder that hospital trustees and directors often find it nearly impossible to conduct their institutions in accordance with the best business principles as we understand them today.

The magnitude of the problem, even locally, can be grasped when it is realized that the valuation of the grounds, buildings and equipment of only twenty-eight hospitals in Pittsburgh amounts to $26,875,944.31; that their total current expenses amounted to $7,484,195.93 in 1931, and that the cost of their free work during the year was $2,397,126.94. Isn't it obvious that enormous savings could be effected if better integration and better coordination than we have today were possible?

Broad vision is essential for community planning, with emphasis on the medical needs of the community and how best to meet such needs, rather than on how best to serve an individual institution or a group in control of such an institution. No new hospital, hospital addition or clinic should be built unless it is first demonstrated that there is need for such a building, and none should be opened unless the need for it is admitted by some central, informed and responsible body, possibly state or municipal.

We realize, of course, that much of the criticism against the hospital, particularly from the medical point of view, has been leveled against the clinic or out-patient department. I believe that much of this criticism as it concerns the well managed, well organized clinic is without actual foundation. There has been too much academic reasoning, too little study of the facts involved in the case.

Medical social work is comparatively new, and the medical social worker, striving to find her bearings in a new profession, may at times arrogate to herself a province that belongs to someone else. The hospital administrator, not close enough to the social and economic requirements of patients who come to his institution, often fails to grasp the functional limitation of the medical social worker and her department. The doctor, without a grounding in the social sciences, forgets too often the great and controlling social and economic forces that lie in the patient's background, the knowledge and proper interpretation of which cannot but help him in his diagnosis and treatment of the patient's ailment.

Must Apply Logic of Facts

Dispensary abuse has been discussed pro and con at meetings of medical associations and of hospital directors. Yet I am ready to say that when we apply to the subject the logic of facts rather than the logic of academic reasoning little indeed of dispensary abuse is found in the well managed clinic. A department store extends credit to thousands of its customers. A small percentage of them fail to pay their bills and so prove themselves not entitled to the credit privilege the store extended. Shall we say that the privilege should be denied to all, because a few have failed to meet their just debts? The same thing holds true for the clinic. Surveys and studies have proved time and again that so-called dispensary abuse amounts to anywhere from 1 to 4 per cent of the intake of the clinic. In the well managed clinic, approximately this percentage of patients are referred back to the private doctor because they are able to pay his fee.

Now, specifically concerning the physician's free

work in the hospital, what does he give and what does he get?

I happen to be one of those who do not believe in getting something for nothing. The term "free" is a misnomer; it does not exist in natural law. In the construction of a bridge or a building, the engineer measures his steel against the strain or burden it is expected to carry; similarly, in human relations, there is always or there should be a *quid pro quo*.

Public Is More Medically-Minded

Today the hospital and the clinic are the arena for medical education and practical instruction. While the prime purpose in the establishment of the institution is the care of the sick, it is in the hospital that the doctor, even after graduation and after internship, learns and keeps abreast of the advances in medical knowledge and technique. The lecture room in the medical school has become secondary to the hospital ward, to the operating room, to the clinic, as the place for instruction. The hospital has given the practical reply to the statement made by Sir William Osler when he said: "For the student of medicine and surgery, it is a safe rule to have no teaching without a patient for a text. . . . The best teaching is that taught by the patient himself."

The emphasis that has been placed by the clinic and the hospital on early diagnosis and its proper interpretation and on the social and economic relationships that affect the patient's physical condition, has resulted in a more medically-minded community, and a more medically-minded community means greater contact with the individual physician for both the cure and the prevention of disease. An educated public will be a public more mindful of its health and more apt to consult the qualified physician before the onset of serious disease.

Physicians Should Be Paid

What, then, are some of the elements to be considered in reaching a solution of the problem? It does not seem altogether reasonable, with the growing size and volume of out-patient work, to expect the medical practitioner to give his services endlessly on an entirely free basis. Consideration should be given to the positive advantages accruing to the physician through his connection with the hospital, but beyond that some provision should be made for payment for his service. If we ever reach the day when we have proper coordination of medical facilities, hospitals should find themselves with adequate funds to pay for medical services in this way. I am convinced that some compensation should be provided for the physician's services in the clinic; the exact form of this compensation is a matter to be determined.

The building of hospitals and their coordination should be put on a practical basis and adjusted to the medical demands of the community. Hospital charges should be put on a businesslike basis. The rate paid by the hospital's paying patient, whether he is in a private room, semiprivate room or a ward, should cover all costs for such service to the hospital and no more. The so-called free work done by the hospital, whether for in-patients or out-patients, should be paid for in full through municipal, county and state subsidy on a per capita per diem basis. Money raised by the institution itself through contributions from private individuals should be used for special experimental and research work and for endowments for the payment of definite stipends to the medical personnel needed in the various departments of the hospital.

Both Have Common Interests

The hospital cannot exist, of course, without the doctor, but the doctor needs the hospital. The great development of medicine as a science and the emphasis laid on laboratories and costly instruments and tests requiring the utmost in accuracy make large scale organization essential in this day and age.

It is not the doctor against the hospital or clinic, or the hospital against the doctor—one means little or nothing without the other. They have common interests. How can both be given their just due in a comprehensive plan that will give fair consideration and proper weight to the needs of the doctor, the patient, the hospital and the community?

Medical practice today is no longer a purely private matter between the doctor and the patient. It is a public matter with increasing social and economic problems. We may well give heed to the statement made by Dr. Charles Russell Bardeen, dean of the medical school, University of Wisconsin, in his expression of the new viewpoint, when he says: "Medical service is essentially a social science; medical art, a social art. The medical student needs as never before a training that will enable him to take an intelligent view of social questions."

What we need more than anything else today is keen and farsighted statesmanship in medical practice and hospital administration, which will carry within itself the power to weld seemingly conflicting forces into a unified, organized, cooperative body, working whole-heartedly for the good of mankind.[1]

[1]Read at a meeting of the Allegheny County Medical Society, Pittsburgh.

Editorials

Postconvention Thoughts

A GLANCE at the program of the thirty-fourth annual convention of the American Hospital Association reveals the trend of institutional thought. The financially worried superintendent in attendance must have found some solace in the knowledge that the majority of his colleagues were troubled by the same economic problems that confronted him. Rarely have references to the methods of conserving and originating revenue appeared so frequently on a national association program.

Of a group of more than two hundred delegates, but three reported that their institutions had realized on last year's activity. Approximately a dozen announced that no deficit was incurred, while in the remainder of the institutions a loss was sustained.

And yet, withal, there was a current of optimism running through the whole convention. There were many who spoke of economic difficulties in retrospect as of a past event—an unpleasant dream from which there had occurred a pleasant awakening. Many expressed the belief that a new concept of the obligations and duties of the voluntary hospital is being formed, and that it is no longer considered mandatory for a hospital to accept an unlimited number of free patients, a procedure that often spells financial ruin for the institution. Not a few executives believed that to care for ward patients at a less than cost rate adequately met the obligation of the hospital to the less fortunate or less provident men and women of the locality.

Facts That Should Be Broadcast

NEWTON D. BAKER, chairman of the Welfare and Relief Mobilization, within the last ten days made public a report on hospitals, public health nursing and tuberculosis in the United States, and forcefully called attention to the fact that unemployed wage earners and exhausted family savings are registered throughout the country in increased demands for free nursing and hospital care.

The report contains the following significant passage on hospitals:

"The continued operation of many of the hospitals in the United States is now being threatened. The number of patients who cannot pay for needed hospitalization has increased rapidly since 1929. Fifteen per cent of the patients in our hospitals in 1931 could not pay for the services rendered them. In the same year 110 private hospitals in the country closed their doors as a result of economic conditions reflected in decreased earnings, decreased contributions and increased free service.

"Economic surveys recently conducted in five states, Texas, Pennsylvania, Illinois, Indiana and Wisconsin, show that almost all of the hospitals not supported by taxes are carrying a large amount of charity work averaging from 30 to 40 per cent of their total service. Of the hospitals reporting to the United Hospital Fund of New York City, for the year 1931, forty-three general and special hospitals and branches gave 788,062 days of hospital care to indigent patients accepted by the city as charges. This service cost these hospitals $3,800,000 for which they received $1,600,000 or 42 per cent of the cost. The difference had to come from charitable gifts, legacies and income from charitable gifts and income from invested funds. In certain communities at present payment for public charges, inadequate enough at best, is being delayed or reduced, in an effort to lower taxes or because of the impaired credit of municipalities. With reduced financial support the continued operation of our hospitals is threatened.

"In many cities hospitals come under the community chest and receive grants from it. Hospitals have not as yet shared in any of the emergency relief funds although they give free care to a large number of the unemployed."

This report is an example of the type of material being sent out by the Association of Community Chests and Councils, New York City, and allied organizations. Our readers are urged to obtain such literature and study it. The facts presented will be invaluable to them in bringing before their communities the needs of their hospitals during the coming winter. The suggestions offered can be adapted to local situations in stimulating interest and the result should be a finer appreciation of hospitals and a larger support for them.

More Light From the Committee on the Costs of Medical Care

FOR four and a half years a distinguished group of physicians and laymen has been laboring to obtain reliable information concerning not only the cost of being ill but also health factors that affect the life of the individual and of the family. The geographic incidence of various types of disease, the methods by which the average

citizen meets his expenses for the protection of his family against ill health and the percentage of those who, on becoming ill, seek the service of the hospital represent but a few of the problems that have received the consideration of this group.

The distinguished chairman of this committee has recently seen fit to append his signature to a number of articles appearing in lay journals setting forth in part the findings of his committee. It is of interest, of course, to know that the people of the United States spent seventy cents per capita each year for the prevention of illness, and that they lost one hundred and twenty-two times as much by illness as they paid each year for the prevention of disease. Such statistics should be convincing to the most obtuse and prejudiced.

When it is considered that the annual cost of working days lost because of illness amounts to a billion dollars annually and when it is remembered that if the wage earner is disabled, community agencies are often required to support members of his family, the local application of the necessity for the prevention of illness, particularly at this time of economic disorganization, can be easily made. It would be a most short-sighted plan to attempt in any way to compare in importance the financial aspects of the case with those that relate to the actual saving of life.

That certain insurance companies have found it to their interest to spend vast sums on preventive medicine is proved by the statement that in twenty years of this effort, the average length of life among their policy holders has increased nine and one-quarter years, while the general increase of length of life in the United States during this period was but five and one-half years.

There are many personal angles to the problem of reducing sickness expense. Patients frequently elect to engage de luxe medical and hospital services when they are unable to pay for them. Certainly to fail to meet such obligations smacks of actual dishonesty. It is, however, as dishonest for a patient to accept dispensary care when he is able to reimburse a physician for his services.

It is hoped that the Committee on the Costs of Medical Care, in making recommendations for remedying the conditions discovered, will refrain from suggesting the necessity for the state to assume the responsibility for the care of the indigent sick. It is obviously the duty of the individual physician and of medical and hospital organizations working together to provide for such economic emergencies, or if they are unable to do so to suggest to tax collecting agencies the proper plan to pursue. In this matter the hospital must play an important part. Whether the committee will be able to offer solutions that will prove practicable and in every way justify the expense of this study remains to be seen. Whatever its recommendations, the carefully considered opinions of so distinguished a group of men and women should bear much weight. Moreover, the hospital field should endeavor in every way possible to study thoroughly and to exemplify practically any measures thus recommended which seem to offer a solution for its own financial and social problems and for those of the members of its clientele.

Speaking of Economies—

AN UNWRITTEN rule governs the relationship between the hospital administrator and the visiting staff, limiting the territory of the administrator somewhat sharply when he approaches the field of the medical or surgical technician. Negotiations between the two are often carried on through diplomatic channels. Medical statistics are not for the administrator to interpret and he may use them or not depending in a large measure on his judgment as to their reception by and influence on the contributing public. In some instances a sympathetic approach from both sides of the dividing line has been cautiously but successfully attempted and has been helpful in bringing about a better understanding between these two great forces that must find the way to harmony in caring for the patient, who is after all the final reason for their existence.

It is not for the administrator to question the surgical judgment of the staff, nor the quantity and quality of the operations that they perform day in and day out. Nor is the lay public in a position to make an intelligent decision. Fortunately or unfortunately, the prevailing financial depression is having the effect of limiting the number of major surgical operations, for the patient, who judges surgical value in terms of price and who is compelled to make decisions with an eye on his purse, feels that he must distinguish between necessities and luxuries. We may be approaching a time when the surgeon will have to be more convincing with the patient and his other medical advisers and when corroborative opinion will be sought before a surgical operation will be permitted. Surgical operations are expensive to everyone concerned, from all points of view. One of the most prominent of pediatricians remarked somewhat cynically not so long ago that the law ought to prohibit a charge of more than five dollars for the performance of a tonsillectomy.

We are reminded to comment thus because of the annual oration on the subject before the Medical Society of London by Sir James Berry on

May 9. In reporting this address, which is entitled "Fallen Idols—The Case of Appendicitis," the *Lancet* for May 14 writes the following significant statements in the discussion of the main theme.

"Sir James Berry was careful to make it plain that the idols were not persons, but fashions, modes of treatment and opinions, which he had seen topple from their pedestals or give ominous signs of doing so during his exactly fifty years of professional life. . . . A good deal might be said, Sir James Berry continued, about the idol of surgical statistics and the illogical and careless way in which such statistics were used. It would be a good plan to have a law which compelled surgeons to submit all surgical statistics to a professional statistician for his comments and advice before publication was permitted. . . .

"He added a few words about tonsils and adenoids. The operation was now worshipped blindly by the profession, though he thought he saw a little unsteadiness of this idol on its pedestal. Nor could he avoid an unpleasant feeling that all was not well in gynecology and obstetrics. Cesarean section was being overdone. He also protested against other unnecessary operations, such as those for exophthalmic goiter, extensive operations in hopelessly inoperable carcinoma and so forth. In conclusion he added that if he looked back upon his own life in somewhat pessimistic mood, recalling cases when the patient's life might have been saved or prolonged if he had done something different, his solace was that throughout his career he had tried to do his best, and there he left the matter."

We do not wish to appear unsympathetic, but it seems to us that hospitals may be coming into an era when fewer surgical operations will be performed per capita as a result of the stimulating influences of the prevailing depression and the conservative attitude of which the retrospective Sir James appears to be the prophet.

An Expensive Economy

IN AN Eastern city, a group of suave and convincing salesmen recently placed before the financially harassed hospital superintendents of the community a brand of ether priced considerably below standard and time proved brands. Not a few impetuously purchased this drug without insisting upon an authoritative chemical analysis. The results of its use were all but disastrous before the harmful impurities of this product were discovered.

How dangerously unstable has the erstwhile good judgment of the executive become because of economic pressure! To purchase cheap drugs is often to suffer loss because of dishonest weight or of impurity of constituents. To buy for use as a general anesthetic, ether that has not withstood the test of time, is to gamble with human life. How foolhardy is such a practice and how criminal are the acts of the salesman who knowingly foists such a product on the market. Let not the will-o'-the-wisp of cheap buying delude the executive into believing that he is practicing true economy. Human life is as priceless now as in other days, when human judgment was clearer and courage higher.

Should Student Nurses Be Paid?

IN SEARCHING for possible means of retrenchment, the attention of many hospital governing boards has been attracted to the large sum required for the payment of the honoraria to student nurses.

The pupil in training usually receives from eight dollars to fifteen dollars a month in addition to her instruction, board, room and laundry. In some schools, and they are far in the minority, no fee is paid the student. In a still smaller group, the pupil is required to pay a tuition fee ranging from one hundred dollars to three hundred dollars. Such a situation no doubt appears strange at first to many persons. To cease paying one hundred dollars a year per nurse and instead to collect a similar sum for tuition would seem like good business. But the solution of this phase of the hospital's financial problem is not so simple. Usually, that which is obtained for nothing is worth just what it costs. Moreover, there often is a close relationship between the size of the pupil's honorarium and the type of instruction that she receives. The more time consumed by the student nurse in performing the menial work of the ward maid, the greater amount of money can the hospital afford to pay the nurse. If classroom and clinical facilities are of a high type, the student's monthly stipend usually is smaller.

Student nurses should not receive an honorarium if a proper curriculum is offered, if classroom and other teaching facilities are adequate, if ward maids and men are at hand to perform janitorial and other miscellaneous services, if a sufficient graduate personnel is available to care for patients during the pupil's periods of didactic instruction. The financial condition of the hospital and of the school's applicants must also be considered. To cease paying student nurses and at the same time to fail to improve educational facilities is manifestly unfair.

Approved Hospital List Gains 123 Names This Year

THE American College of Surgeons surveyed only 145 more hospitals of twenty-five beds and over this year than it did in 1931 in its hospital standardization program, yet 123 hospitals, or twenty-eight more than last year, were added to the fully approved list. Of an additional 155 hospitals surveyed in 1931, only ninety-five were added to the fully approved list.

The number of hospitals surveyed for the year ending October 1, 1932, totaled 3,464. Of this number 2,294 were fully or conditionally approved —2,094 being fully approved, and 200 conditionally approved. The total bed capacity of the hospitals surveyed was 514,150, of which 448,401 were in hospitals approved by the American College of Surgeons. During the year, taking a 65 per cent occupancy with an average stay of twelve days, it is estimated that approximately 8,743,819 patients received 104,925,828 days' care in approved institutions.

The list of approved hospitals for the United States, Canada and other countries, as announced at the Hospital Standardization Conference in St. Louis, October 17 to 21, is presented here in full.

Summary Statistics Showing Number and Percentage of Approved Hospitals

1. Hospitals of 100 beds and over:

Surveyed	1,565
Fully approved	1,418
Percentage fully approved	90.6
Conditionally approved	51
Percentage conditionally approved	3.3
Not approved	96
Percentage not approved	6.1
Total fully and conditionally approved	1,469
Total percentage fully and conditionally approved	93.9

2. Hospitals of 50 to 99 beds:

Surveyed	1,035
Fully approved	549
Percentage fully approved	53
Conditionally approved	99
Percentage conditionally approved	9.6
Not approved	387
Percentage not approved	37.4
Total fully and conditionally approved	648
Total percentage fully and conditionally approved	62.6

3. Hospitals of 25 to 49 beds:

Surveyed	864
Fully approved	127
Percentage fully approved	14.7
Conditionally approved	50
Percentage conditionally approved	5.8
Not approved	687
Percentage not approved	79.5
Total fully and conditionally approved	177
Total percentage fully and conditionally approved	20.5

4. Government Hospitals:

(a) Army:

Surveyed	5
Fully approved	5
Percentage fully approved	100.0

(b) Navy:

Surveyed	16
Fully approved	16
Percentage fully approved	100.0

(c) Public Health Service:

Surveyed	25
Fully approved	25
Percentage fully approved	100.0

(d) Veterans Bureau:

Surveyed	70
Fully approved	70
Percentage fully approved	100.0

5. Other Countries:

Twenty-eight hospitals of other countries have been awarded full approval, and are included in the List of Approved Hospitals for 1932.

Summary

Total surveyed	3,464
Total fully approved	2,094
Total percentage fully approved	60.4
Total conditionally approved	200
Total percentage conditionally approved	5.8
Total not approved	1,170
Total percentage not approved	33.8
Total fully and conditionally approved	2,294
Total percentage fully and conditionally approved:	
Hospitals 100 beds and over	93.9
Hospitals 50 beds and over	81.4
Hospitals 25 beds and over	66.2

ALABAMA

Name of Hospital and Location	Capacity
ANNISTON	
Garner Hospital	66
BESSEMER	
Bessemer General Hospital	85
BIRMINGHAM	
Birmingham Baptist Hospital	167
Children's Hospital	50
Hillman Hospital	340
Norwood Hospital	210
St. Vincent's Hospital	125
South Highlands Infirmary	137
DECATUR	
Benevolent Society Hospital	42
DOTHAN	
Frasier-Ellis Hospital	75
Moody Hospital	100
FAIRFIELD	
Employees' Hospital of the Tennessee Coal, Iron and Railroad Company	310
GADSDEN	
Holy Name of Jesus Hospital	35
JASPER	
Walker County Hospital	50
MOBILE	
City Hospital	180
Mobile Infirmary	100
Providence Infirmary	100
United States Marine Hospital	90
MONTGOMERY	
St. Margaret's Hospital	132
SELMA	
Goldsby King Memorial Hospital	60
Vaughan Memorial Hospital	77
SYLACAUGA	
Drummond-Fraser Hospital	30
Sylacauga Infirmary	50
TUSCALOOSA	
Veterans' Administration Hospital	273
TUSKEGEE	
Veterans' Administration Hospital	804
TUSKEGEE INSTITUTE	
John A. Andrew Memorial Hospital	75

ARIZONA

BISBEE	
Copper Queen Hospital	41
GANADO	
Sage Memorial Hospital	80
GLOBE	
Gila County Hospital	65
JEROME	
United Verde Copper Company Hospital	56
MIAMI	
Miami-Inspiration Hospital	48
PHOENIX	
Good Samaritan Hospital	117
St. Joseph's Hospital	184
PRESCOTT	
Mercy Hospital	43
TUCSON	
St. Mary's Hospital and Sanatorium	150
Southern Methodist Hospital and Sanatorium	125
Southern Pacific Sanatorium	100
Veterans' Administration Hospital	358
WHIPPLE BARRACKS	
Veterans' Administration Hospital	600

ARKANSAS

EL DORADO	
*Henry C. Rosamond Memorial Hospital	50
Warner Brown Hospital	75
FAYETTEVILLE	
Fayetteville City Hospital	61
FORT SMITH	
St. Edward's Mercy Hospital	115
St. John's Hospital	62
Sparks Memorial Hospital	118
HOPE	
Josephine Hospital	28
HOT SPRINGS	
*Army and Navy General Hospital	100
Leo N. Levi Memorial Hospital	75
St. Joseph's Hospital	154
JONESBORO	
St. Bernard's Hospital	100
LITTLE ROCK	
*Arkansas Children's Hospital	76
Baptist State Hospital	300
Little Rock City Hospital	140
Missouri Pacific Hospital	135
St. Vincent's Infirmary	150
NORTH LITTLE ROCK	
Veterans' Administration Hospital	820
RUSSELLVILLE	
*St. Mary's Hospital	60
TEXARKANA	
Michael Meagher Memorial Hospital	75
St. Louis Southwestern Hospital	150

CALIFORNIA

ALAMEDA	
*Alameda Sanatorium on the South Shore	84
ALHAMBRA	
Alhambra Hospital	55
ARLINGTON	
Riverside County Hospital	287
BAKERSFIELD	
Mercy Hospital	84
BERKELEY	
Alta Bates Hospital	136
Ernest V. Cowell Memorial Hospital, University of California	100
BURBANK	
Burbank Hospital	51
COMPTON	
Compton Sanitarium and Las Campanas Hospital	222
EAST OAKLAND	
East Oakland Hospital	105
FORT BRAGG	
Redwood Coast Hospital	25
FRENCH CAMP	
*San Joaquin General Hospital	420
FRESNO	
General Hospital of Fresno County	390
St. Agnes Hospital	82
GLENDALE	
Glendale Sanitarium and Hospital	254
Physicians and Surgeons Hospital	86
LA JOLLA	
Scripps Memorial Hospital	62
LIVERMORE	
Arroyo Sanitarium	190
Veterans' Administration Hospital	318
LOMA LINDA	
Loma Linda Sanitarium and Hospital	164
LONG BEACH	
Harriman Jones Clinic and Hospital	25
Long Beach Community Hospital	120
Seaside Hospital	300
LOS ANGELES	
*Angelus Hospital	210
California Hospital	307
Cedars of Lebanon Hospital	290
Children's Hospital	184
French Hospital	107
Golden State Hospital	77
Hollywood Clara Barton Memorial Hospital	302
Hospital of the Good Samaritan	425
Methodist Hospital of Southern California	249
Orthopedic Hospital	75
Queen of the Angels Hospital	155
St. Vincent's Hospital	272
Santa Fe Coast Lines Hospital	144
Veterans' Administration Hospital	857
White Memorial Hospital	132
MARE ISLAND	
United States Naval Hospital	721
MONTEREY	
Monterey Hospital	49
MONTEREY PARK	
Garfield Hospital	40
NATIONAL CITY	
Paradise Valley Sanitarium and Hospital	117
OAKLAND	
Children's Hospital of the East Bay	65
Fabiola Hospital	112
Highland Hospital of Alameda County	456
Peralta Hospital	168
Providence Hospital	234
Samuel Merritt Hospital	170
ORANGE	
Orange County General Hospital	230
St. Joseph Hospital	125
OXNARD	
St. John's Hospital	59
PALO ALTO	
Veterans' Administration Hospital	1010
PASADENA	
Pasadena Hospital	213
POMONA	
Pomona Valley Community Hospital	96
RIVERSIDE	
Riverside Community Hospital	43
ROSS	
Ross General Hospital	70
SACRAMENTO	
Mater Misericordiæ Hospital	174
Sacramento Hospital	475
Sutter Hospital	224
SAN BERNARDINO	
St. Bernardine's Hospital	141
San Bernardino County Charity Hospital	315
SAN DIEGO	
Mercy Hospital	325
San Diego County General Hospital	672
United States Naval Hospital	1045
SAN FERNANDO	
Veterans' Administration Hospital	230
SAN FRANCISCO	
Franklin Hospital	215
French Hospital	228
Hospital for Children	300
Letterman General Hospital	1055
Mary's Help Hospital	160
Mount Zion Hospital	198
St. Francis Hospital	353
St. Joseph's Hospital	263
St. Luke's Hospital	225
St. Mary's Hospital	289
San Francisco Hospital	1295
Shriners' Hospital for Crippled Children	60
Southern Pacific General Hospital	425
Stanford University Hospitals	335
United States Marine Hospital	472
University of California Hospitals	287
SANITARIUM	
St. Helena Sanitarium and Hospital	146
SAN JOSE	
O'Connor Sanitarium	134
San Jose Hospital	141
Santa Clara County Hospital	499
SAN LEANDRO	
Fairmont Hospital of Alameda County	875
SAN MATEO	
Community Hospital of San Mateo County	153
Mills Memorial Hospital	111
SAN PEDRO	
San Pedro General Hospital	139
United States Naval Hospital Ship Relief	367
SANTA ANA	
*Santa Ana Valley Hospital	70
SANTA BARBARA	
St. Francis Hospital of Santa Barbara	166
Santa Barbara Cottage Hospital	250
Santa Barbara General Hospital	235
SANTA MONICA	
Santa Monica Hospital	101
STOCKTON	
St. Joseph's Home and Hospital	141
TORRANCE	
Jared Sidney Torrance Memorial Hospital	50
VENTURA	
E. P. Foster Memorial Hospital	64
VETERANS HOME	
Veterans Home of California	250
WESTWOOD	
*Westwood Hospital	100
WOODLAND	
Woodland Clinic Hospital	130

COLORADO

BOULDER	
Boulder-Colorado Sanitarium	120
Community Hospital	60
COLORADO SPRINGS	
Beth-El General Hospital	100
Cragmor Sanatorium	150
Glockner Sanatorium and Hospital	225
National Methodist Episcopal Sanatorium for Tuberculosis	70
St. Francis Hospital	154
DENVER	
Agnes Memorial Sanatorium	158
Beth Israel Hospital	85
Children's Hospital	175
Denver General Hospital	515
Fitzsimons General Hospital	1848
Mercy Hospital	165
National Jewish Hospital	270
Porter Sanitarium and Hospital	100
Presbyterian Hospital of Colorado	175
St. Anthony's Hospital	200
St. Joseph's Hospital	225
St. Luke's Hospital	255
Sanatorium of the Jewish Consumptives' Relief Society	300
University of Colorado Hospitals (Colorado General Hospital, Colorado Psycopathic Hospital)	260
DURANGO	
Mercy Hospital	42
FORT LYON	
Veterans' Administration Hospital	589
GRAND JUNCTION	
St. Mary's Hospital	74
GREELEY	
Greeley Hospital	130
LA JUNTA	
Atchison, Topeka and Santa Fe Railroad Hospital	36
*Mennonite Hospital and Sanitarium	80
LONGMONT	
Longmont Hospital	40
PUEBLO	
Corwin Hospital of the Colorado Fuel and Iron Company	240
Parkview Hospital	80
St. Mary Hospital	162
SALIDA	
Denver and Rio Grande Western Hospital Association's Hospital	85
*Red Cross Hospital	42
STERLING	
St. Benedict Hospital	36
TRINIDAD	
Mt. San Rafael Hospital	80

CONNECTICUT

BRIDGEPORT	
Bridgeport Hospital	415
St. Vincent's Hospital	250
BRISTOL	
Bristol Hospital	100
DANBURY	
Danbury Hospital	128
DERBY	
Griffin Hospital	100
GREENWICH	
Greenwich Hospital	125
HARTFORD	
Hartford Hospital	721
Mount Sinai Hospital	79

*Conditionally approved.

Municipal Hospital 145
St. Francis Hospital 580
MERIDEN
Meriden Hospital 136
MIDDLETOWN
Middlesex Hospital 150
NEW BRITAIN
New Britain General Hospital 236
NEW HAVEN
Grace Hospital 286
Hospital of St. Raphael 250
New Haven Hospital 410
NEWINGTON
Veterans' Administration Hospital 266
NEW LONDON
Home Memorial Hospital 60
Lawrence and Memorial Associated Hospitals 230
NORWALK
Norwalk General Hospital 159
NORWICH
William W. Backus Hospital 155
PUTNAM
*Day Kimball Hospital 80
SOUTH MANCHESTER
Manchester Memorial Hospital 64
STAMFORD
Stamford Hospital 266
TORRINGTON
Charlotte Hungerford Hospital 150
WATERBURY
St. Mary's Hospital 250
Waterbury Hospital 321
WILLIMANTIC
St. Joseph's Hospital 50
WINSTED
*Litchfield County Hospital 75

DELAWARE

FARNHURST
Delaware State Hospital 725
LEWES
Beebe Hospital of Lewes 60
WILMINGTON
Delaware Hospital 200
Homeopathic Hospital 190
St. Francis Hospital 87
Wilmington General Hospital 139

DISTRICT OF COLUMBIA

WASHINGTON
Central Dispensary and Emergency Hospital 280
Children's Hospital of the District of Columbia 182
Columbia Hospital for Women and Lying-in Asylum 204
Episcopal Eye, Ear, and Throat Hospital 100
Freedmen's Hospital 270
Gallinger Municipal Hospital 650
Garfield Memorial Hospital 311
Georgetown University Hospital 291
George Washington University Hospital .. 124
National Homeopathic Hospital 80
Providence Hospital 325
St. Elizabeth's Hospital 5000
Sibley Memorial Hospital 300
United States Naval Hospital 427
Veterans' Administration Hospital 260
Walter Reed General Hospital 1112
Washington Sanitarium and Hospital 175

FLORIDA

CENTURY
Turberville Hospital 39
CLEARWATER
Morton F. Plant Endowed Hospital 39
DAYTONA BEACH
Halifax District Hospital 125
FORT LAUDERDALE
*Memorial Hospital 28
GAINESVILLE
Alachua County Hospital 60
University of Florida Infirmary 31
JACKSONVILLE
Brewster Hospital 75
Duval County Hospital 185
Riverside Hospital 40
St. Luke's Hospital 175
St. Vincent's Hospital 150
KEY WEST
United States Marine Hospital 112
LAKE CITY
Veterans' Administration Hospital 307
LAKELAND
Morrell Memorial Hospital 93
MIAMI
Dade County Hospital 108
James M. Jackson Memorial Hospital 325
Victoria Hospital 72
MIAMI BEACH
St. Francis Hospital 65
OCALA
Munroe Memorial Hospital 105
ORLANDO
*Orange General Hospital 170
*Orlando-Florida Sanitarium and Hospital 119
PENSACOLA
Pensacola Hospital 125
United States Naval Hospital 204
ST. AUGUSTINE
East Coast Hospital 70
Flagler Hospital 85
ST. PETERSBURG
City Hospitals (Mound Park—Mercy) 96
St. Anthony's Hospital 55
TALLAHASSEE
*Florida Agricultural and Mechanical College Hospital 44
TAMPA
Children's Hospital of Tampa 26
Tampa Municipal Hospital 194
WEST PALM BEACH
Good Samaritan Hospital 139

GEORGIA

ALBANY
Phoebe Putney Memorial Hospital 46
ATHENS
Athens General Hospital 73
ATLANTA
Crawford W. Long Memorial Hospital 142
Georgia Baptist Hospital 150
Grady Memorial Hospital 600
Henrietta Egleston Hospital for Children 54
Piedmont Hospital 134
St. Joseph's Infirmary 137
United States Penitentiary Hospital 179
Veterans' Administration Hospital 200
Wesley Memorial Hospital 185
AUGUSTA
Universtiy Hospital 257
Veterans' Administration Hospital 755
Wilhenford Hospital for Women and Children 54
CANTON
*Coker's Hospital 25
COLUMBUS
City Hospital 125
CUTHBERT
Patterson Hospital 28
DECATUR
Scottish Rite Hospital for Crippled Children 30
GAINESVILLE
Downey Hospital 52
MACON
Macon Hospital 170
Middle Georgia Sanatorium 58
MILLEN
Millen Hospital 25
PLAINS
Wise Sanitarium 54
ROME
Harbin Hospital 75
McCall Hospital 50
SAVANNAH
Central of Georgia Railway Hospital 62
United States Marine Hospital 146
THOMASVILLE
John D. Archbold Memorial Hospital 115
WAYCROSS
Atlantic Coast Lines Hospital 75
*Ware County Hospital 75

IDAHO

BOISE
St. Alphonsus Hospital 120
St. Luke's Hospital 124
Veterans' Administration Hospital 206
IDAHO FALLS
Idaho Falls Latter Day Saints Hospital 100
LEWISTON
St. Joseph's Hospital 100
NAMPA
Mercy Hospital 52
POCATELLO
Pocatello General Hospital 60
St. Anthony's Mercy Hospital 54
WALLACE
Providence Hospital 69

ILLINOIS

ALTON
St. Joseph's Hospital 75
AURORA
Copley Hospital 95
St. Joseph Mercy Hospital 132
BERWYN
Berwyn Hospital 93
BLUE ISLAND
St. Francis Hospital 104
CAIRO
St. Mary's Infirmary 100
CHAMPAIGN
*Burnham City Hospital 86
CHICAGO
Albert Merritt Billings Hospital 216
Alexian Brothers Hospital 288
American Hospital 130
Augustana Hospital 405
Bethany Sanitarium and Hospital 50
Chicago Eye, Ear, Nose, and Throat Hospital 75
Chicago Lying-in Hospital and Dispensary 260
Chicago Memorial Hospital 103
Children's Memorial Hospital 275
Columbus Hospital 153
Cook County Hospital 3300
Edgewater Hospital 146
Englewood Hospital 131
Evangelical Deaconess Hospital 86
Evangelical Hospital of Chicago 260
Frances E. Willard National Temperance Hospital 185
Garfield Park Hospital 223
Grant Hospital 305
Henrotin Hospital 85
Holy Cross Hospital 118
Hospital of St. Anthony de Padua 265
Illinois Central Hospital 250
Illinois Eye and Ear Infirmary 237
Illinois Masonic Hospital 170
Jackson Park Hospital 225
John B. Murphy Hospital 140
Lake View Hospital 140
Lewis Memorial Maternity Hospital 500
Lutheran Deaconess Home and Hospital .. 218
Lutheran Memorial Hospital 150
*Martha Washington Hospital 72
Mercy Hospital 405
Michael Reese Hospital 606
Misericordia Hospital and Home for Infants 110
Mother Cabrini Memorial Hospital 173
Mount Sinai Hospital 200
Municipal Contagious Disease Hospital 428
Municipal Tuberculosis Sanitarium 1250
Passavant Memorial Hospital 250
Post-Graduate Hospital 85
Presbyterian Hospital 439
*Provident Hospital 65
Ravenswood Hospital 193
Research and Educational Hospitals of the State of Illinois 175
Roseland Community Hospital 100
St. Anne's Hospital 310
St. Bernard's Hospital 200
St. Elizabeth's Hospital 287
St. Joseph's Hospital 220
St. Luke's Hospital 671
St. Mary of Nazareth Hospital 300
Shriners' Hospital for Crippled Children 62
South Chicago Community Hospital 85
South Shore Hospital 125
Swedish Covenant Hospital 200
United States Marine Hospital 150
University Hospital of Chicago 121
Washington Boulevard Hospital 110
Wesley Memorial Hospital 275
*West Side Hospital 161
Women and Children's Hospital 125
DANVILLE
Lake View Hospital 170
St. Elizabeth's Hospital 183
Veterans' Administration Hospital 560
DECATUR
Decatur and Macon County Hospital 142
Wabash Employees' Hospital 85
DE KALB
De Kalb Public Hospital 52
DIXON
Dixon Public Hospital 60
DWIGHT
Veterans' Administration Hospital 225
EAST ST. LOUIS
Christian Welfare Hospital 62
St. Mary's Hospital 300
ELGIN
Sherman Hospital 106
EVANSTON
Evanston Hospital 274
St. Francis Hospital 350
EVERGREEN PARK
Little Company of Mary Hospital 150
FREEPORT
*Evangelical Deaconess Hospital 100
*St. Francis Hospital 124
GALESBURG
Galesburg Cottage Hospital 115
GENEVA
Community Hospital 85
GRANITE CITY
St. Elizabeth's Hospital 76
GREAT LAKES
United States Naval Hospital 800
HARVEY
Ingalls Memorial Hospital 120
HIGHLAND PARK
Highland Park Hospital 70
HINES
Veterans' Administration Hospital 1750
HINSDALE
Hinsdale Sanitarium and Hospital 149
JACKSONVILLE
Our Savior's Hospital 86
Passavant Memorial Hospital 86
JOLIET
St. Joseph's Hospital 232
Silver Cross Hospital 151
KANKAKEE
St. Mary Hospital 157
KEWANEE
Kewanee Public Hospital 69
St. Francis Hospital 60
MELROSE PARK
Westlake Hospital 94
MOLINE
Lutheran Hospital 75
Moline Public Hospital 150
MONMOUTH
Monmouth Hospital 45
MURPHYSBORO
St. Andrew's Hospital 50

NORTH CHICAGO
Veterans' Administration Hospital....1135
OAK PARK
Oak Park Hospital.... 175
West Suburban Hospital.... 427
OLNEY
Olney Sanitarium.... 80
OTTAWA
John Stewart Ryburn Memorial Hospital 75
PANA
*Huber Memorial Hospital.... 50
PEORIA
*St. Francis Hospital.... 335
QUINCY
Blessing Hospital.... 150
St. Mary's Hospital.... 216
ROCKFORD
Rockford Hospital.... 110
St. Anthony's Hospital.... 233
Swedish-American Hospital.... 92
ROCK ISLAND
St. Anthony's Hospital.... 150
SPRINGFIELD
Palmer Tuberculosis Sanatorium.... 75
STERLING
Public Hospital of the City of Sterling.... 63
WAUKEGAN
St. Therese's Hospital.... 208
Victory Memorial Hospital.... 90

INDIANA

ANDERSON
St. John's Hospital.... 85
CROWN POINT
Lake County Tuberculosis Sanatorium.... 128
EAST CHICAGO
St. Catherine's Hospital.... 360
EVANSVILLE
Protestant Deaconess Hospital.... 160
St. Mary's Hospital.... 125
United States Marine Hospital.... 54
Walker Hospital.... 105
FORT WAYNE
*Fort Wayne Lutheran Hospital.... 189
*Methodist Episcopal Hospital.... 140
St. Joseph's Hospital.... 350
FRANKFORT
Clinton County Hospital.... 50
GARY
Illinois Steel Company, Gary Hospital.... 120
Methodist Hospital.... 100
St. Mary's Mercy Hospital.... 265
HAMMOND
St. Margaret's Hospital.... 250
INDIANAPOLIS
Indianapolis City Hospital.... 518
Indiana University Hospitals—
Robert W. Long Hospital
James Whitcomb Riley Hospital for Children
William H. Coleman Hospital for Women
420
Methodist Episcopal Hospital.... 662
*St. Francis Hospital.... 162
St. Vincent's Hospital.... 285
Veterans' Administration Hospital.... 152
JEFFERSONVILLE
Clark County Memorial Hospital.... 35
LA FAYETTE
La Fayette Home Hospital.... 155
St. Elizabeth's Hospital.... 250
MARION
*Grant County Hospital.... 55
Veterans' Administration Hospital.....1400
MICHIGAN CITY
Clinic Hospital.... 60
St. Anthony's Hospital.... 100
MISHAWAKA
St. Joseph's Hospital.... 110
MUNCIE
Ball Memorial Hospital.... 160
NEW ALBANY
St. Edward's Hospital.... 125
PRINCETON
Methodist Episcopal Hospital.... 35
RICHMOND
Reid Memorial Hospital.... 146
SOUTH BEND
Epworth Hospital.... 187
St. Joseph Hospital.... 175
SULLIVAN
Mary Sherman Hospital.... 60
TERRE HAUTE
St. Anthony's Hospital.... 181
Union Hospital.... 198

IOWA

AMES
Iowa State College Hospital.... 90
ANAMOSA
*Mercy Hospital.... 35
BURLINGTON
Burlington Hospital.... 125
Mercy Hospital.... 145
CARROLL
*St. Anthony Hospital.... 132
CEDAR RAPIDS
Mercy Hospital.... 175
St. Luke's Methodist Hospital.... 175
CENTERVILLE
St. Joseph's Hospital.... 50
CLINTON
Jane Lamb Memorial Hospital.... 112
St. Joseph Mercy Hospital.... 85
COUNCIL BLUFFS
Jennie Edmundson Memorial Hospital.... 135
Mercy Hospital.... 147
DAVENPORT
Mercy Hospital.... 135
St. Luke's Hospital.... 127
DES MOINES
Iowa Lutheran Hospital and Iowa Lutheran Maternity Hospital.... 140
Iowa Methodist Hospital.... 275
Mercy Hospital.... 171
Polk County Public Hospitals—
Broadlawns Division.... 100
*General Division.... 109
DUBUQUE
Finley Hospital.... 112
FORT DODGE
St. Joseph's Mercy Hospital.... 125
FORT MADISON
*Atchison, Topeka, and Santa Fe Hospital 60
GRINNELL
Community Hospital.... 60
HAMPTON
Lutheran Hospital.... 54
IOWA CITY
Mercy Hospital.... 75
State University of Iowa, University Hospitals.... 1004
KEOKUK
Graham Protestant Hospital.... 78
St. Joseph's Hospital.... 135
KNOXVILLE
Veterans' Administration Hospital.... 851
LE MARS
Sacred Heart Hospital.... 50
MASON CITY
Park Hospital.... 65
St. Joseph's Mercy Hospital.... 75
NEW HAMPTON
St. Joseph's Hospital.... 60
OTTUMWA
*Ottumwa Hospital.... 65
St. Joseph's Hospital.... 75
Sunnyslope Sanatorium.... 53
SIOUX CITY
Lutheran Hospital.... 75
Methodist Hospital.... 120
St. Joseph's Mercy Hospital.... 200
St. Vincent's Hospital.... 125
WASHINGTON
Washington County Hospital.... 35
WATERLOO
Allen Memorial Hospital.... 58
St. Francis Hospital.... 90
WAVERLY
St. Joseph Mercy Hospital.... 56

KANSAS

ARKANSAS CITY
*Mercy Hospital.... 40
BELOIT
Community Hospital.... 60
CONCORDIA
St. Joseph's Hospital.... 85
DODGE CITY
St. Anthony's Hospital.... 80
EL DORADO
Susan B. Allen Memorial Hospital.... 50
ELLSWORTH
Ellsworth Hospital.... 40
FORT LEAVENWORTH
United States Penitentiary Annex Hospital.... 152
FORT SCOTT
Mercy Hospital.... 105
GARDEN CITY
*St. Catherine's Hospital.... 36
GREAT BEND
St. Rose Hospital.... 113
HALSTEAD
Halstead Hospital.... 203
HAYS
Hays Protestant Hospital.... 51
St. Anthony's Hospital.... 122
HUTCHINSON
Grace Hospital.... 149
St. Elizabeth's Mercy Hospital.... 83
INDEPENDENCE
*Mercy Hospital.... 87
KANSAS CITY
Bell Memorial Hospital.... 210
Bethany Methodist Hospital.... 160
Providence Hospital.... 77
St. Margaret's Hospital.... 264
LEAVENWORTH
St. John's Hospital.... 50
United States Penitentiary Hospital.... 172
Veterans' Administration Hospital.... 448
LIBERAL
Epworth Hospital.... 51
MULVANE
Atchison, Topeka, and Santa Fe Hospital 50
Axtell Christian Hospital.... 53
Bethel Deaconess Hospital.... 60
PARSONS
Missouri-Kansas-Texas Railroad Employes' Hospital.... 65
PITTSBURG
Mt. Carmel Hospital.... 81
SABETHA
St. Anthony Murdock Memorial Hospital 100
SALINA
St. John's Hospital.... 72
TOPEKA
Atchison, Topeka, and Santa Fe Hospital 140
Christ's Hospital.... 114
Jane C. Stormont Hospital.... 85
St. Francis Hospital.... 87
WELLINGTON
Hatcher Hospital.... 30
WICHITA
St. Francis Hospital.... 300
Wesley Hospital.... 235
Wichita Hospital.... 119
WINFIELD
St. Mary's Hospital.... 50
William Newton Memorial Hospital.... 52

KENTUCKY

BEREA
Berea College Hospital.... 125
BOWLING GREEN
*City Hospital.... 52
COVINGTON
St. Elizabeth's Hospital.... 375
DAYTON
*Speers Memorial Hospital.... 112
GLASGOW
Community Hospital.... 59
JENKINS
Jenkins Hospital.... 57
LEXINGTON
Good Samaritan Hospital.... 246
St. Joseph's Hospital.... 225
Shriners' Hospital for Crippled Children—Mobile Unit.... 28
Veterans' Administration Hospital.... 250
LOUISVILLE
Children's Free Hospital.... 75
Jewish Hospital.... 99
J. N. Norton Memorial Infirmary.... 167
Kentucky Baptist Hospital.... 150
Kosair Crippled Children Hospital.... 60
Louisville City Hospital.... 400
Methodist Episcopal Deaconess Hospital.... 75
St. Anthony's Hospital.... 150
St. Joseph's Infirmary.... 326
Sts. Mary and Elizabeth Hospital.... 145
United States Marine Hospital.... 83
LYNCH
Lynch Hospital of the United States Coal and Coke Company.... 56
MURRAY
William Mason Memorial Hospital.... 65
OUTWOOD
Veterans' Administration Hospital.... 375
PADUCAH
Illinois Central Hospital.... 90
Riverside Hospital.... 138
PARIS
W. W. Massie Memorial Hospital.... 50
PIKEVILLE
*Methodist Hospital of Kentucky.... 35

LOUISIANA

ALEXANDRIA
Baptist Hospital.... 65
Veterans' Administration Hospital.... 439
BATON ROUGE
*Baton Rouge General Hospital.... 75
Our Lady of the Lake Hospital.... 110
BOGALUSA
Elizabeth Sullivan Memorial Hospital.... 107
CARVILLE
United States Marine Hospital.... 372
HAYNESVILLE
Haynesville Hospital.... 27
JACKSON
Parker Hospital of the East Louisiana Hospital for Insane.... 60
LAKE CHARLES
St. Patrick's Sanitarium.... 75
MONROE
St. Francis Sanitarium.... 140
*Vaughan-Wright-Bendel Clinic Hospital.. 37
NEW ORLEANS
Eye, Ear, Nose and Throat Hospital.... 70
Flint-Goodridge Hospital of Dillard University.... 100
French Hospital.... 80
Hotel Dieu.... 261
Illinois Central Hospital.... 70
Mercy Hospital—Soniat Memorial.... 155
Southern Baptist Hospital.... 212
State of Louisiana Charity Hospital.....1756
Touro Infirmary.... 383
United States Marine Hospital.... 569
PINEVILLE
Fuqua Memorial Hospital of the Central Louisiana State Hospital for the Insane.... 40
SHREVEPORT
Highland Sanitarium.... 116

North Louisiana Sanitarium 100
Shreveport Charity Hospital 350
Shreveport Sanitarium and T. E. Schumpert Memorial Hospital 150
Shriners' Hospital for Crippled Children .. 60
Tri-State Hospital 125

MAINE

AUGUSTA
Augusta General Hospital 80
Veterans' Administration Hospital 324
BANGOR
Eastern Maine General Hospital 150
BATH
Bath City Hospital 63
BELFAST
Waldo County General Hospital 33
FARMINGTON
Franklin County Memorial Hospital 58
GARDINER
Gardiner General Hospital 56
LEWISTON
Central Maine General Hospital 125
St. Mary's General Hospital 150
PORTLAND
Children's Hospital 100
Maine Eye and Ear Infirmary 125
Maine General Hospital 193
St. Barnabas Hospital 65
State Street Hospital 67
United States Marine Hospital 72
PRESQUE ISLE
*Presque Isle General Hospital 60
RUMFORD
Rumford Community Hospital 75
SANFORD
Henrietta D. Goodall Hospital 53
WATERVILLE
Sisters' Hospital 100
Thayer Hospital 36

MARYLAND

ANNAPOLIS
United States Naval Hospital 220
BALTIMORE
Baltimore City Hospitals 1863
Bon Secours Hospital 65
Children's Hospital 120
Church Home and Infirmary 175
Franklin Square Hospital 135
Hospital for the Women of Maryland 134
Howard A. Kelly Hospital 35
Johns Hopkins Hospital 750
Maryland General Hospital 232
Mercy Hospital 280
Provident Hospital and Free Dispensary .. 122
St. Agnes Hospital 208
St. Joseph's Hospital 276
Sinai Hospital 271
South Baltimore General Hospital 115
Union Memorial Hospital 268
United States Marine Hospital 167
University Hospital of the University of Maryland 250
Volunteers of America Hospital 40
West Baltimore General Hospital 165
CAMBRIDGE
Cambridge-Maryland Hospital 89
CUMBERLAND
Allegany Hospital of the Sisters of Charity 100
Memorial Hospital 148
EASTON
Emergency Hospital 101
FREDERICK
Frederick City Hospital 125
HAGERSTOWN
Washington County Hospital 122
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James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children 62
PERRY POINT
Veterans' Administration Hospital 1015
SALISBURY
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ADAMS
W. B. Plunkett Memorial Hospital 53
AMESBURY
Amesbury Hospital 36
ARLINGTON
Symmes Arlington Hospital 100
ATTLEBORO
Sturdy Memorial Hospital 125
AYER
*Community Memorial Hospital 28
BEDFORD
Veterans' Administration Hospital 644
BEVERLY
Beverly Hospital 146
BOSTON
Beth Israel Hospital 190
Boston City Hospital 2000
Boston Floating Hospital 48
Boston Lying-in Hospital 204
Carney Hospital 210
Children's and Infants' Hospital 302
Collis P. Huntington Memorial Hospital .. 25
Emerson Hospital 65
Evangeline Booth Maternity Hospital and Home 60
Faulkner Hospital 100
Harley Private Hospital 83
Hart Private Hospital 75
House of the Good Samaritan 75
Long Island Hospital 575
Massachusetts Eye and Ear Infirmary 209
Massachusetts General Hospital 974
Massachusetts Memorial Hospitals 602
Massachusetts Women's Hospital 81
New England Baptist Hospital 150
New England Deaconess Hospital 265
New England Hospital for Women and Children 240
Peter Bent Brigham Hospital 247
Robert Breck Brigham Hospital 115
St. Elizabeth's Hospital 300
St. Margaret's and St. Mary's Lying-in Hospitals 136
Salvation Army Roxbury Hospital and Clinic 31
BROCKTON
Brockton Hospital 158
Goddard Hospital 75
BROOKLINE
Brooks Hospital 50
Free Hospital for Women 94
CAMBRIDGE
Cambridge City Hospital 114
Cambridge Hospital 300
CHELSEA
Captain John Adams Hospital of Soldiers' Home in Massachusetts 227
Chelsea Memorial Hospital 117
United States Marine Hospital 167
United States Naval Hospital 660
CLINTON
Clinton Hospital 87
CONCORD
Emerson Hospital in Concord 48
EVERETT
Whidden Memorial Hospital 115
FALL RIVER
Fall River General Hospital 312
St. Anne's Hospital 116
Truesdale Hospital 120
Union Hospital in Fall River 175
FITCHBURG
Burbank Hospital 211
FRAMINGHAM
Framingham-Union Hospital 160
GARDNER
Henry Heywood Memorial Hospital 100
GLOUCESTER
Addison Gilbert Hospital 65
GREENFIELD
Franklin County Public Hospital 106
HAVERHILL
Municipal Hospitals 246
HOLDEN
Holden District Hospital 26
HOLYOKE
Holyoke Hospital 150
Providence Hospital 144
LAWRENCE
Lawrence General Hospital 147
LEOMINSTER
Leominster Hospital 73
LOWELL
Lowell General Hospital 130
St. John's Hospital 157
St. Joseph's Hospital 108
LYNN
Lynn Hospital 203
MALDEN
Malden Hospital 118
MEDFORD
Lawrence Memorial Hospital 105
MELROSE
Melrose Hospital 120
New England Sanitarium and Hospital 165
MIDDLEBOROUGH
Lakeville State Sanatoruim 304
MILFORD
*Milford Hospital 55
MILTON
Milton Hospital and Convalescent Home .. 38
MONTAGUE CITY
Farren Memorial Hospital 92
NATICK
Leonard Morse Hospital 57
NEW BEDFORD
St. Luke's Hospital 330
NEWBURYPORT
Anna Jaques Hospital 60
Newburyport Homeopathic Hospital 28
NEWTON LOWER FALLS
Newton Hospital 240
NORTH ADAMS
North Adams Hospital 100
NORTHAMPTON
Cooley Dickinson Hospital 154
Veterans' Administration Hospital 555
NORTH WILMINGTON
North Reading State Sanatorium 297
NORWOOD
Norwood Hospital 100
PALMER
Wing Memorial Hospital 35
PEABODY
Josiah B. Thomas Hospital 59
PITTSFIELD
House of Mercy Hospital 222
St. Luke's Hospital 165
QUINCY
Quincy City Hospital 250
RUTLAND
Rutland State Sanatorium 370
Veterans' Administration Hospital 420
SALEM
North Shore Babies' Hospital 50
Salem Hospital 137
SOMERVILLE
Somerville Hospital 80
SOUTHBRIDGE
*Harrington Memorial Hospital 36
SOUTH WEYMOUTH
*Weymouth Hospital 63
SPRINGFIELD
*Health Department Hospital 100
Mercy Hospital 400
Shriners' Hospital for Crippled Children .. 60
Springfield Hospital 198
Wesson Maternity Hospital 112
Wesson Memorial Hospital 122
TAUNTON
Morton Hospital 75
VINEYARD HAVEN
United States Marine Hospital 25
WALTHAM
Waltham Hospital 215
WARE
Mary Lane Hospital 46
WESTFIELD
Noble Hospital 108
Westfield State Sanatorium 306
WINCHESTER
Winchester Hospital 85
WOBURN
Charles Choate Memorial Hospital 61
WORCESTER
City Hospital 400
Fairlawn Hospital 61
Memorial Hospital 215
St. Vincent Hospital 250
Worcester Hahnemann Hospital 122
WRENTHAM
Pondville Hospital at Norfolk 115

MICHIGAN

ALBION
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ANN ARBOR
St. Joseph's Mercy Hospital 148
University Hospital 1234
BATTLE CREEK
Battle Creek Sanitarium 1011
Leila Y. Post Montgomery Hospital 200
Nichols Memorial Hospital 100
BAY CITY
Mercy Hospital 160
BENTON HARBOR
Mercy Hospital 51
CADILLAC
Mercy Hospital 48
CALUMET
*Calumet and Hecla Mining Company Hospital 26
CAMP CUSTER
Veterans' Administration Hospital 774
DETROIT
Charles Godwin Jennings Hospital 72
Children's Hospital of Michigan 479
*Delray General Hospital 95
*Detroit Eye, Ear, Nose, and Throat Hospital 75
*Dunbar Memorial Hospital 79
*East Side General Hospital 65
Evangelical Deaconess Hospital 135
*Florence Crittenton Hospital and Home 330
Grace Hospital 352
Harper Hospital 471
Henry Ford Hospital 607
Herman Kiefer Hospital 1400
Jefferson Clinic and Diagnostic Hospital 63
*Lincoln Hospital 90
Michigan Mutual Hospital 35
Providence Hospital 452
Receiving Hospital 760
St. Joseph's Mercy Hospital 200
St. Mary's Hospital 375
United States Marine Hospital 132
Woman's Hospital 312
ELOISE
Eloise Infirmary 6600
FLINT
Hurley Hospital 410
Women's Hospital 64
GOODRICH
Goodrich General Hospital 30
GRAND RAPIDS
Blodgett Memorial Hospital 150
Butterworth Hospital 270
St. Mary's Hospital 253
GROSSE POINTE
Cottage Hospital of Grosse Pointe 58
HAMTRAMCK
*St. Francis Hospital 45
HANCOCK
St. Joseph's Hospital 68

HIGHLAND PARK
Highland Park General Hospital 195
IRONWOOD
Grand View Hospital 61
ISHPEMING
Ishpeming Hospital 46
JACKSON
Mercy Hospital 124
W. A. Foote Memorial Hospital 151
KALAMAZOO
Borgess Hospital 350
Bronson Methodist Hospital 143
LANSING
Edward W. Sparrow Hospital 145
St. Lawrence Hospital 130
MARQUETTE
*St. Luke's Hospital 58
MONROE
*Mercy Hospital 78
MT. CLEMENS
St. Joseph Sanitarium and Hospital 162
MUSKEGON
Hackley Hospital 125
Mercy Hospital 124
Muskegon County Sanatorium 70
NILES
*Pawating Hospital 46
OWOSSO
Memorial Hospital 100
PONTIAC
Pontiac General Hospital 120
St. Joseph Mercy Hospital 189
SAGINAW
Saginaw County Contagious Hospital 80
Saginaw General Hospital 156
St. Luke's Hospital 62
St. Mary's Hospital 194
ST. JOHNS
Clinton Memorial Hospital 59
SAULT STE. MARIE
Chippewa County War Memorial Hospital 61
THREE RIVERS
*Three Rivers Hospital 37
WYANDOTTE
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MINNESOTA

ALBERT LEA
*Naeve Hospital 80
ALEXANDRIA
*Douglas County Hospital 35
BRAINERD
St. Joseph's Hospital 74
CROOKSTON
*Bethesda Hospital 45
St. Vincent's Hospital 57
DULUTH
St. Luke's Hospital 270
St. Mary's Hospital 290
EVELETH
More Hospital 38
FERGUS FALLS
*George B. Wright Memorial Hospital 62
St. Luke's Hospital 77
GRACEVILLE
Western Minnesota Hospital 42
HIBBING
*Adams Hospital 32
Rood Hospital 43
LITTLE FALLS
St. Gabriel's Hospital 50
MANKATO
Immanuel Hospital 75
St. Joseph's Hospital 139
MINNEAPOLIS
Abbott Hospital 100
Asbury Hospital 168
Eitel Hospital 120
Fairview Hospital 225
Hill Crest Surgical Hospital 80
Lutheran Deaconess Home and Hospital 150
Maternity Hospital 119
Minneapolis General Hospital 756
Northwestern Hospital 200
St. Andrew's Hospital 100
St. Barnabas Hospital 190
St. Mary's Hospital 290
Shriners' Hospital for Crippled Children 62
Swedish Hospital 332
Universtiy Hospital 405
Veterans' Administration Hospital 554
NOPEMING
Nopeming Sanatorium 225
OAK TERRACE
Glen Lake Sanatorium 698
RED WING
St. John's Hospital 90
ROCHESTER
Colonial Hospital 250
Kahler Hospital 165
St. Mary's Hospital 624
Worrell Hospital 185
ST. CLOUD
St. Cloud Hospital 210
Veterans' Administration Hospital 494
ST. PAUL
Ancker Hospital 1000
Bethesda Hospital 110
Charles T. Miller Hospital 216
Children's Hospital 70
Gillette State Hospital for Crippled Children 250
Midway Hospital 128
Mounds Park Sanitarium 137
Northern Pacific Beneficial Association Hospital 162
St. John's Hospital 96
St. Joseph's Hospital 275
St. Luke's Hospital 160
*St. Paul Hospital 68
STILLWATER
Lakeview Memorial Hospital 50
THIEF RIVER FALLS
St. Luke's Hospital 44
WADENA
*Wesley Hospital 50
WARREN
Warren Hospital 47
WILLMAR
Willmar Hospital 42
WINONA
Winona General Hospital 124

MISSISSIPPI

BILOXI
Biloxi Hospital 58
BROOKHAVEN
*King's Daughters' Hospital 50
CENTREVILLE
*Field Memorial Hospital 36
COLUMBIA
Columbia Clinic Hospital 35
CORINTH
McRae Hospital 60
ELECTRIC MILLS
George C. Hixon Memorial Hospital 50
GREENVILLE
King's Daughters' Hospital (White) 114
GULFPORT
King's Daughters' Hospital 100
Veterans' Administration Hospital 598
HATTIESBURG
South Mississippi Infirmary 75
HOUSTON
Houston Hospital 27
JACKSON
Jackson Infirmary 67
Mississippi Baptist Hospital 100
MERIDIAN
*Anderson Infirmary 45
*Matty Hersee Hospital 110
Meridian Sanitarium 51
Rush's Infirmary 48
NATCHEZ
*Chamberlain-Rice Hospital 75
Natchez Charity Hospital 140
Natchez Sanatorium 40
OXFORD
*Oxford Hospital 30
SANATORIUM
Mississippi State Tuberculosis Sanatorium 480
STATE COLLEGE
James Z. George Memorial Hospital 44
TUPELO
Tupelo Hospital 35
VICKSBURG
Vicksburg Hospital 68
Vicksburg Infirmary 40
Vicksburg Sanitarium and Crawford Street Hospital 75
WINONA
Winona Infirmary 35

MISSOURI

BOONVILLE
St. Joseph's Hospital 75
CAPE GIRARDEAU
St. Francis Hospital 50
Southeast Missouri Hospital 65
CARTHAGE
McCune-Brooks Hospital 50
CLAYTON
St. Louis County Hospital 198
COLUMBIA
Boone County Hospital 53
University Hospitals, University of Missouri 92
EXCELSIOR SPRINGS
Veterans' Administration Hospital 252
HANNIBAL
*Levering Hospital 78
St. Elizabeth Hospital 70
INDEPENDENCE
Independence Sanitarium 80
JEFFERSON BARRACKS
Veterans' Administration Hospital 372
JEFFERSON CITY
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St. Mary's Hospital 60
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Freeman Hospital 92
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KANSAS CITY
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St. Joseph Hospital 251
St. Luke's Hospital 246
St. Mary's Hospital 175
Trinity Lutheran Hospital 135
Veterans' Administration Hospital 200
Wheatley-Provident Hospital 67
LOUISIANA
*Pike County Hospital 50
MARYVILLE
St. Francis Hospital 91
MOBERLY
Wabash Employes' Hospital 40
ST. CHARLES
St. Joseph's Hospital 56
ST. JOSEPH
Missouri Methodist Hospital 220
St. Joseph's Hospital 150
ST. LOUIS
Alexian Brothers Hospital 225
Barnard Free Skin and Cancer Hospital 44
Barnes Hospital 270
Bethesda Hospital 101
Christian Hospital 130
City Sanitarium 2185
De Paul Hospital 285
Evangelical Deaconess Home and Hospital 180
Frisco Employes' Hospital 100
Isolation Hospital 250
Jewish Hospital of St. Louis 304
Lutheran Hospital 195
Missouri Baptist Hospital 486
Missouri Pacific Hospital 300
Mount St. Rose Sanatorium 150
Robert Koch Hospital 501
St. Anthony's Hospital 250
St. John's Hospital 333
St. Louis Children's Hospital 210
St. Louis City Hospital 750
*St. Louis City Hospital No. 2 445
St. Louis Maternity Hospital 208
St. Luke's Hospital 216
St. Mary's Hospital 310
St. Mary's Infirmary 135
Shriners' Hospital for Crippled Children 120
United States Marine Hospital 100
SPRINGFIELD
Burge Hospital 93
St. John's Hospital 118
Springfield Baptist Hospital 100

MONTANA

ANACONDA
St. Ann's Hospital 75
BILLINGS
*Billings Deaconess Hospital 67
St. Vincent's Hospital 172
BOZEMAN
*Bozeman Deaconess Hospital 70
BUTTE
Murray Hospital 135
St. James Hospital 165
FORT HARRISON
Veterans' Administration Hospital 306
GLENDIVE
Northern Pacific Beneficial Association Hospital 71
GREAT FALLS
Columbus Hospital 340
Montana Deaconess Hospital 253
HAVRE
Kennedy Deaconess Hospital 53
Sacred Heart Hospital 62
HELENA
St. John's Hospital 60
St. Peter's Hospital 60
KALISPELL
Kalispell General Hospital 60
LEWISTOWN
St. Joseph's Hospital 85
MILES CITY
Holy Rosary Hospital 100
MISSOULA
Northern Pacific Beneficial Association Hospital 72
St. Patrick's Hospital 120
Thornton Hospital 37

NEBRASKA

ALLIANCE
St. Joseph's Hospital 94
BEATRICE
Lutheran Hospital 66
COLUMBUS
St. Mary's Hospital 208
FALLS CITY
Falls City Hospital 35
GRAND ISLAND
St. Francis Hospital 130
LINCOLN
Bryan Memorial Hospital 103
Lincoln General Hospital 148
St. Elizabeth's Hospital 200
Veterans' Administration Hospital 197
McCOOK
*St. Catherine of Sienna Hospital 65

OMAHA
Bishop Clarkson Memorial Hospital 110
Creighton Memorial, St. Joseph's Hospital 455
Douglas County Hospital 215
Evangelical Covenant Hospital 122
Immanuel Hospital 136
Nebraska Methodist Episcopal Hospital 250
St. Catherine's Hospital 170
University of Nebraska Hospital 237
SCOTTSBLUFF
*West Nebraska Methodist Episcopal Hospital 60

NEVADA

EAST ELY
Steptoe Valley Hospital 48
ELKO
Elko General Hospital 50
RENO
St. Mary's Hospital 68

NEW HAMPSHIRE

BERLIN
Hospital St. Louis 60
CLAREMONT
Claremont General Hospital 70
CONCORD
Margaret Pillsbury General Hospital 110
New Hampshire Memorial Hospital 85
DOVER
Wentworth Hospital 84
EXETER
*Exeter Hospital 52
GRASMERE
Hillsborough County General Hospital 135
HANOVER
Mary Hitchcock Memorial Hospital 140
KEENE
Elliot Community Hospital 86
LACONIA
Laconia Hospital 62
MANCHESTER
Balch Hospital 30
Elliot Hospital 88
L'Hopital De Notre Dame De Lourdes 85
Sacred Heart Hospital 88
NASHUA
Nashua Memorial Hospital 90
St. Joseph Hospital 115
PORTSMOUTH
Portsmouth Hospital 80
United States Naval Hospital 166

NEW JERSEY

ATLANTIC CITY
Atlantic City Hospital 316
BAYONNE
Bayonne Hospital and Dispensary 200
BRIDGETON
Bridgeton Hospital 99
CAMDEN
Cooper Hospital 325
West Jersey Homeopathic Hospital 267
EAST ORANGE
Homeopathic Hospital of Essex County 120
ELIZABETH
Alexian Brothers Hospital 170
Elizabeth General Hospital and Dispensary 226
St. Elizabeth Hospital 260
ENGLEWOOD
Englewood Hospital 195
FRANKLIN
*Franklin Hospital 37
HACKENSACK
Hackensack Hospital 225
HOBOKEN
St. Mary's Hospital 425
IRVINGTON
Irvington General Hospital 89
JERSEY CITY
Christ Hospital 119
Jersey City Hospital 600
Margaret Hague Maternity Hospital 575
St. Francis Hospital 250
KEARNY
West Hudson Hospital 52
LONG BRANCH
Monmouth Memorial Hospital 209
LYONS
Veterans' Administration Hospital 895
MONTCLAIR
Montclair Community Hospital 81
Mountainside Hospital 250
St. Vincent's Hospital 59
MORRISTOWN
All Souls Hospital 102
Morristown Memorial Hospital 174
MOUNT HOLLY
Burlington County Hospital 122
NEPTUNE
Raleigh Fitkin-Paul Morgan Memorial Hospital 161
NEWARK
Babies' Hospital 60
Hospital and Home for Crippled Children 125
Hospital for Women and Children 110
Hospital of St. Barnabas 138
Newark Beth Israel Hospital 420
Newark City Hospital 700
Newark Eye and Ear Infirmary 62
Newark Memorial Hospital 157
Presbyterian Hospital 265
St. James Hospital 125
St. Michael's Hospital 300
NEW BRUNSWICK
Middlesex General Hospital 105
St. Peter's General Hospital 150
ORANGE
New Jersey Orthopedic Hospital and Dispensary 85
Orange Memorial Hospital 388
St. Mary's Hospital 120
PASSAIC
Passaic General Hospital 225
St. Mary's Hospital 225
PATERSON
Nathan and Miriam Barnert Memorial Hospital 110
Paterson General Hospital 320
St. Joseph's Hospital 490
PERTH AMBOY
Perth Amboy City Hospital 154
PLAINFIELD
Muhlenberg Hospital 275
PRINCETON
Princeton Hospital 70
RAHWAY
Rahway Memorial Hospital 120
RIDGEWOOD
Bergen County Hospital 400
SECAUCUS
Hudson County Hospital 210
SOMERVILLE
Somerset Hospital 86
SUMMIT
Overlook Hospital 125
TEANECK
Holy Name Hospital 258
TRENTON
Mercer Hospital 210
New Jersey State Hospital 2700
St. Francis Hospital 314
*Trenton Municipal Colony Hospitals 414
William McKinley Memorial Hospital 146
VERONA
Essex Mountain Sanatorium 422
VINELAND
Newcomb Hospital 100
WEEHAWKEN
*North Hudson Hospital 166

NEW MEXICO

ALBUQUERQUE
Atchison, Topeka, and Santa Fe Hospital 70
St. Joseph Sanatorium and Hospital 250
Veterans' Administration Hospital 259
CLOVIS
*Atchison, Topeka, and Santa Fe Hospital 32
FORT BAYARD
Veterans' Administration Hospital 450
FORT STANTON
United States Marine Hospital 270
GALLUP
St. Mary's Hospital 100
RATON
*New Mexico Miners' Hospital 35
ROSWELL
St. Mary's Hospital 68
SANTA FE
St. Vincent Hospital and Sanatorium 80

NEW YORK

ALBANY
Albany Hospital 540
Anthony N. Brady Maternity Home 120
*Child's Hospital 50
Memorial Hospital 140
St. Peter's Hospital 150
AMSTERDAM
Amsterdam City Hospital 86
St. Mary's Hospital 128
AUBURN
Auburn City Hospital 155
BATAVIA
*Batavia Hospital 58
St. Jerome's Hospital 72
BATH
Veterans' Administration Hospital 395
BAY SHORE
Southside Hospital 98
BINGHAMTON
Binghamton City Hospital 414
BRONX
Veterans' Administration Hospital 950
BRONXVILLE
Lawrence Hospital 105
BROOKLYN
Bay Ridge Sanitarium 103
Beth-El Hospital 244
Beth Moses Hospital 226
Brooklyn Eye and Ear Hospital 178
Brooklyn Hospital 429
Bushwick Hospital 116
Caledonian Hospital of the City of New York 130
Carson C. Peck Memorial Hospital 110
Coney Island Hospital 330
Cumberland Hospital 330
Greenpoint Hospital 300
Hospital of the Holy Family 63
House of St. Giles the Cripple 98
Israel-Zion Hospital 430
Jewish Hospital of Brooklyn 655
Kings County Hospital 1660
Kingston Avenue Hospital 460
Long Island College Hospital 480
Lutheran Hospital 110
Methodist Episcopal Hospital 400
Norwegian Lutheran Deaconesses' Home and Hospital 201
Prospect Heights Hospital and Brooklyn Maternity 226
St. Catherine's Hospital 296
St. John's Hospital 234
St. Mary's Hospital of the City of Brooklyn 307
St. Peter's Hospital 250
Wyckoff Heights Hospital of Brooklyn 200
BUFFALO
Buffalo City Hospital 863
Buffalo Columbus Hospital 79
Buffalo General Hospital 400
Buffalo Hospital of the Sisters of Charity 215
Children's Hospital of Buffalo 250
Deaconess Hospital 227
Emergency Hospital of the Sisters of Charity 100
Memorial Hospital of Buffalo 65
Mercy Hospital 161
Millard Fillmore Hospital 300
St. Mary's Maternity Hospital 150
United States Marine Hospital 85
CAMBRIDGE
Mary McClellan Hospital 112
CANANDAIGUA
Frederick Ferris Thompson Hospital 113
Veterans' Administration Hospital 468
CASTLE POINT
Veterans' Administration Hospital 479
CLIFTON SPRINGS
Clifton Springs Sanitarium and Clinic 471
COHOES
Cohoes Hospital 60
COOPERSTOWN
Mary Imogene Bassett Hospital 80
CORNING
*Corning Hospital 110
CORNWALL
Cornwall Hospital 70
CORTLAND
Cortland County Hospital 135
DOBBS FERRY
Dobbs Ferry Hospital 50
ELLIS ISLAND
United States Marine Hospital 540
ELMIRA
Arnot-Ogden Memorial Hospital 207
St. Joseph's Hospital 192
ENDICOTT
Ideal Hospital of Endicott 135
FAR ROCKAWAY
St. Joseph's Hospital 100
FLUSHING
Flushing Hospital and Dispensary 243
GENEVA
Geneva General Hospital 92
GLEN COVE
North Country Community Hospital 112
GLENS FALLS
Glens Falls Hospital 95
GLOVERSVILLE
Nathan Littauer Hospital 121
HORNELL
Bethesda Hospital 60
St. James Mercy Hospital 90
HUDSON
Hudson City Hospital 106
ITHACA
Thompkins County Memorial Hospital 184
JAMAICA
Mary Immaculate Hospital 310
Queensboro Hospital 64
JAMESTOWN
Jamestown General Hospital 102
Woman's Christian Association Hospital 130
JOHNSON CITY
Charles S. Wilson Memorial Hospital 200
KINGSTON
Benedictine Hospital 100
Kingston Hospital 135
LACKAWANNA
Moses Taylor Hospital 28
Our Lady of Victory Hospital 129
LONG ISLAND CITY
St. John's Long Island City Hospital 272
MALONE
Alice Hyde Memorial Hospital 89
MIDDLETOWN
Elizabeth A. Horton Memorial Hospital 108
MINEOLA
Nassau Hospital 205
MT. KISCO
Northern Westchester Hospital 99
MOUNT VERNON
Mount Vernon Hospital 180
NEWBURGH
St. Luke's Hospital of Newburgh, N. Y. 176

NEW DORP BEACH, S. I.
St. John's Guild Seaside Hospital 190
NEW ROCHELLE
New Rochelle Hospital 147
NEW YORK CITY
Babies' Hospital of the City of New York 204
Beekman Street Hospital 100
Bellevue Hospital 2069
Beth David Hospital 128
Beth Israel Hospital Medical Center 360
Booth Memorial Hospital 68
*Broad Street Hospital 125
Bronx Hospital 310
Central Neurological Hospital 470
Columbus Hospital 300
Columbus Hospital Extension 104
Community Hospital 110
Fifth Avenue Hospital 301
Fordham Hospital 350
French Benevolent Society Hospital 190
Gouverneur Hospital 210
Harlem Hospital 341
Herman Knapp Memorial Eye Hospital 50
Hospital for Joint Diseases 355
Hospital for the Ruptured and Crippled 275
Hospital of the Rockefeller Institute for Medical Research 60
Jewish Memorial Hospital 117
Knickerbocker Hospital 223
Lebanon Hospital 192
Lenox Hill Hospital 364
Lincoln Hospital 429
Lutheran Hospital of Manhattan 125
Manhattan Eye, Ear, and Throat Hospital 214
Memorial Hospital for the Treatment of Cancer and Allied Diseases 109
Metropolitan Hospital 1620
Midtown Hospital 70
Misericordia Hospital 322
Montefiore Hospital 905
Morrisania Hospital 416
Mount Sinai Hospital 676
Neurological Institute of New York 209
New York City Cancer Institute Hospital 212
New York City Hospital 1060
New York Eye and Ear Infirmary 174
New York Foundling Hospital 305
New York Homeopathic Medical College and Flower Hospital 262
New York Hospital 821
New York Infirmary for Women and Children 164
New York Nursery and Child's Hospital 256
New York Orthopedic Dispensary and Hospital 293
New York Polyclinic Medical School and Hospital 337
New York Post-Graduate Medical School and Hospital 425
Park East Hospital 125
Park West Hospital 78
*Peoples Hospital 58
Presbyterian Hospital in the City of New York 550
Riverside Hospital 332
Roosevelt Hospital 391
St. Elizabeth's Hospital 142
St. Francis' Hospital 400
St. Luke's Hospital 527
St. Mary's Hospital for Children 126
St. Vincent's Hospital of the City of New York 360
Sloane Hospital for Women 319
Stuyvesant Square Hospital 100
Sydenham Hospital 200
United States Naval Hospital 847
West Side Hospital and Dispensary 27
Willard Parker Hospital 448
Woman's Hospital in the State of New York 288
NIAGARA FALLS
Mt. St. Mary's Hospital 145
Niagara Falls Memorial Hospital 191
NORTHPORT, L. I.
Veterans' Administration Hospital 1392
NORWICH
Chenango Memorial Hospital 76
OLEAN
Olean General Hospital 108
ONEIDA
Broad Street Hospital 60
ONEONTA
Aurelia Osborn Fox Memorial Hospital 59
OSSINING-ON-HUDSON
Ossining Hospital 58
Sing Sing Prison Hospital 50
OSWEGO
*Oswego Hospital 89
OTTSVILLE
Municipal Sanatorium 384
PENN YAN
Soldiers and Sailors Memorial Hospital 48
PLATTSBURGH
Champlain Valley Hospital 107
Physicians' Hospital of Plattsburgh 133
PORT CHESTER
United Hospital 200
POUGHKEEPSIE
St. Francis Hospital 135
Vassar Brothers Hospital 204
RICHMOND HILL
Jamaica Hospital 159
ROCHESTER
Genesee Hospital 239
Highland Hospital 256
*Monroe County Hospital 250
Park Avenue Hospital 103
Rochester General Hospital 305
Rochester Municipal Hospital 250
St. Mary's Hospital 200
Strong Memorial Hospital 286
ROCKAWAY BEACH
Rockaway Beach Hospital 100
ROME
Rome Hospital and Murphy Memorial Hospital 82
SARATOGA SPRINGS
Saratoga Hospital 107
SCHENECTADY
Ellis Hospital 285
SOUTHAMPTON
Southampton Hospital 100
STAPLETON, S. I.
United States Marine Hospital 288
SUNMOUNT
Veterans' Administration Hospital 380
SYRACUSE
Crouse-Irving Hospital 234
General Hospital of Syracuse 110
St. Joseph Hospital 231
Syracuse Memorial Hospital 250
University Hospital of the Good Shepherd 267
TARRYTOWN
Tarrytown Hospital 60
TICONDEROGA
Moses-Ludington Hospital 50
TOMPKINSVILLE, S. I.
Staten Island Hospital 275
TROY
Leonard Hospital 62
Samaritan Hospital 175
Troy Hospital 274
UTICA
Faxton Hospital 209
Masonic Soldiers and Sailors Memorial Hospital 200
St. Elizabeth's Hospital 145
St. Luke's Home and Hospital 151
Utica General Hospital 120
Utica Memorial Hospital 75
VALHALLA
Grasslands Hospital 584
WARSAW
Wyoming County Community Hospital 70
WATERTOWN
House of the Good Samaritan 135
Mercy Hospital 125
WAVERLY
Tioga County General Hospital 63
WEST HAVERSTRAW
New York State Reconstruction Home 300
WEST NEW BRIGHTON, S. I.
St. Vincent's Hospital 115
Sea View Hospital 1070
WHITE PLAINS
White Plains Hospital 118
YONKERS
St. John's Riverside Hospital 189
St. Joseph's Hospital 120
Yonkers General Hospital 195

NORTH CAROLINA

ASHEVILLE
Asheville Mission Hospital 124
*Aston Park Hospital 74
BILTMORE
Biltmore Hospital 63
CHARLOTTE
Charlotte Eye, Ear, and Throat Hospital 25
Mercy Hospital 77
New Charlotte Sanatorium 110
Presbyterian Hospital 110
St. Peter's Hospital 78
DURHAM
Duke Hospital 456
Lincoln Hospital 108
Watts Hospital 210
FAYETTEVILLE
Highsmith Hospital 100
*Pittman Hospital 85
GASTONIA
*City Hospital 54
North Carolina Orthopedic Hospital 141
GOLDSBORO
*Goldsboro Hospital 53
GREENSBORO
L. Richardson Memorial Hospital 64
St. Leo's Hospital 100
Sternberger Children's Hospital 42
GREENVILLE
*Pitt Community Hospital 36
HENDERSON
Maria Parham Hospital 30
HICKORY
Richard Baker Hospital 35
HIGH POINT
High Point Hospital 75
KINSTON
Memorial General Hospital 35
*Parrott Memorial Hospital 55
LEAKSVILLE
*Leaksville Hospital 35
LENOIR
Caldwell Hospital 25
LINCOLNTON
Lincoln Hospital 35
LUMBERTON
*Baker Sanatorium 65
*Thompson Memorial Hospital 35
MT. AIRY
Martin Memorial Hospital 50
NORTH WILKESBORO
*Wilkes Hospital 25
OTEEN
Veterans' Administration Hospital 612
PINEHURST
Moore County Hospital 37
RALEIGH
Rex Hospital 126
St. Agnes Hospital 100
ROCKY MOUNT
Atlantic Coast Line Railroad Hospital 50
Park View Hospital 100
RUTHERFORDTON
Rutherford Hospital 64
SALISBURY
*Rowan General Hospital 54
SHELBY
Shelby Hospital 49
STATESVILLE
Davis Hospital 100
Long's Sanatorium 56
TARBORO
Edgecombe General Hospital 48
TRYON
*St. Luke's Hospital 29
WASHINGTON
Tayloe Hospital 35
WAYNESVILLE
*Haywood County Hospital 51
WILMINGTON
Bulluck Hospital 35
James Walker Memorial Hospital 150
WILSON
Moore-Herring Hospital 35
WINSTON-SALEM
City Memorial Hospital 235
North Carolina Baptist Hospital 108
WRIGHTSVILLE SOUND
*Babies' Hospital 40

NORTH DAKOTA

BISMARCK
Bismarck Hospital and Deaconess Home 140
St. Alexius Hospital 140
DEVILS LAKE
Mercy Hospital 56
DICKINSON
St. Joseph's Hospital 80
FARGO
St. John's Hospital 200
St. Luke's Hospital 125
Veterans' Administration Hospital 57
GRAFTON
*Grafton Deaconess Hospital 43
GRAND FORKS
Grand Forks Deaconess Hospital 107
St. Michael's Hospital 70
MINOT
St. Joseph's Hospital 100
Trinity Hospital 220
VALLEY CITY
*Mercy Hospital 85
WILLISTON
*Mercy Hospital 120

OHIO

AKRON
Children's Hospital 110
City Hospital of Akron 350
Peoples Hospital 200
St. Thomas Hospital 182
ALLIANCE
Alliance City Hospital 100
ASHTABULA
*Ashtabula General Hospital 93
BELLAIRE
City Hospital 50
CANTON
Aultman Hospital 160
Mercy Hospital 200
CHILLICOTHE
Veterans' Administration Hospital 614
CINCINNATI
Bethesda Hospital 308
Children's Hospital 221
Christ Hospital 366
Christian R. Holmes Hospital 50
Cincinnati General Hospital 925
Deaconess Hospital 175
Good Samaritan Hospital 550
Hamilton County Tuberculosis Sanatorium 500
Jewish Hospital 288
St. Mary Hospital 200
CIRCLEVILLE
*Berger Municipal Hospital 31
CLEVELAND
Babies' and Children's Hospital 147

Charity Hospital 300
City Hospital 1075
Cleveland Clinic Hospital 229
*Evangelical Deaconess Hospital 144
Fairview Park Hospital 96
Glenville Hospital 100
Grace Hospital 40
Huron Road Hospital 120
Lakeside Hospital 262
Lutheran Hospital 129
Maternity Hospital 300
Mount Sinai Hospital of Cleveland 272
Polyclinic Hospital 130
St. Alexis Hospital 200
St. Ann's Maternity Hospital 110
St. John's Hospital of Cleveland 212
St. Luke's Hospital 322
United States Marine Hospital 250
Woman's Hospital 123

COLUMBUS
Children's Hospital 100
Grant Hospital 303
Hawkes Hospital of Mt. Carmel 243
Mercy Hospital 90
St. Ann's Infant Asylum and Maternity Hospital 50
St. Francis Hospital 160
Starling-Loving University Hospital 276
White Cross Hospital 274

DAYTON
Miami Valley Hospital 396
St. Elizabeth Hospital 420
Veterans' Administration Hospital 1105

DOVER
Union Hospital 85

EAST AKRON
Springfield Lake Sanatorium 238

EAST LIVERPOOL
East Liverpool City Hospital 99

ELYRIA
Elyria Memorial Hospital and Gates Hospital for Crippled Children 154

FINDLAY
*Home and Hospital of the City of Findlay 75

FREMONT
*Memorial Hospital of Sandusky County 58

GALLIPOLIS
Holzer Hospital 55

HAMILTON
*Fort Hamilton Hospital 109
Mercy Hospital 234

LAKEWOOD
Lakewood City Hospital 72

LIMA
Lima Hospital 90
St. Rita's Hospital 116

LORAIN
St. Joseph's Hospital 120

MANSFIELD
Mansfield General Hospital 75

MARION
Sawyer Sanatorium 40

MARTINS FERRY
Martins Ferry Hospital 75

MASSILLON
Massillon City Hospital 105

MIDDLETOWN
Middletown Hospital 100

NEWARK
Newark Hospital 100

OBERLIN
Allen Hospital 36

PIQUA
Memorial Hospital 66

PORTSMOUTH
Mercy Hospital 75
Portsmouth General Hospital 100
Schirrman Hospital 50

SALEM
Salem City Hospital 57

SANDUSKY
Good Samaritan Hospital 65
Providence Hospital 60

SIDNEY
*Wilson Memorial Hospital 27

SOUTH EUCLID
Rainbow Hospital 100

SPRINGFIELD
Springfield City Hospital 150

STEUBENVILLE
Ohio Valley Hospital 125

TOLEDO
Flower Hospital 125
Lucas County Hospital 606
Mercy Hospital 125
Robinwood Hospital 104
St. Vincent's Hospital 390
Toledo Hospital 275
Women's and Children's Hospital 164

TROY
*Stouder Memorial Hospital 51

WARREN
St. Joseph's Riverside Hospital 50
Warren City Hospital 125

WAUSEON
De Ette Harrison Detwiler Memorial Hospital 62

YOUNGSTOWN
St. Elizabeth's Hospital 300
Youngstown Hospital 472

ZANESVILLE
Bethesda Hospital 130
Good Samaritan Hospital 140

OKLAHOMA

ARDMORE
Hardy Sanitarium 44

BARTLESVILLE
Washington County Memorial Hospital 67

CLAREMORE
Claremore Indian Hospital 34

CLINTON
*Clinton Hospital 79

EL RENO
El Reno Sanitarium 60

LAWTON
Kiowa Indian Hospital 100

McALESTER
Albert Pike Hospital 67

MUSKOGEE
*Oklahoma Baptist Hospital 125
Veterans' Administration Hospital 400

OKLAHOMA CITY
Oklahoma City General Hospital 98
Reconstruction Hospital and McBride Clinic 27
St Anthony's Hospital 320
*Samaritan Hospital 49
University Hospitals: (University Hospital; Crippled Children's Hospital) 442
Wesley Hospital 175

PAWNEE
Pawnee-Ponca Hospital 47

PICHER
American Hospital 38

PONCA CITY
Ponca City Hospital 67

SHAWNEE
A. C. H. Hospital 34
Shawnee Indian Sanatorium 150
Shawnee Municipal Hospital 93

SULPHUR
*Soldiers' Tubercular Sanatorium 108

TULSA
Morningside Hospital 250
St. John's Hospital 235

OREGON

ASTORIA
Columbia Hospital 66
St. Mary's Hospital 74

BAKER
*St. Elizabeth's Hospital 95

CORVALLIS
Corvallis General Hospital 46

EUGENE
Eugene Hospital and Clinic 60
Pacific Christian Hospital 96

KLAMATH FALLS
*Hillside Hospital 55
*Klamath Valley Hospital 64

MEDFORD
Sacred Heart Hospital 70

ONTARIO
Holy Rosary Hospital 40

OREGON CITY
Oregon City Hospital 52

PENDLETON
St. Anthony's Hospital 82

PORTLAND
Dr. Robert C. Coffey Clinic and Hospital 100
Doernbecher Memorial Hospital for Children 75
Emanuel Hospital 274
Good Samaritan Hospital 320
Multnomah Hospital 300
Portland Medical Hospital 64
Portland Sanitarium and Hospital 135
St. Vincent's Hospital 450
Shriners' Hospital for Crippled Children 50
Veterans' Administration Hospital 337

SALEM
Salem General Hospital 75

PENNSYLVANIA

ABINGTON
Abington Memorial Hospital 206

ALLENTOWN
Allentown Hospital 325
Sacred Heart Hospital 300

ALTOONA
Altoona Hospital 180
Mercy Hospital 134

ASHLAND
Ashland State Hospital 236

ASPINWALL
Veterans' Administration Hospital 269

BEAVER FALLS
Providence Hospital 65

BELLEVUE
Suburban General Hospital 118

BETHLEHEM
St. Luke's Hospital 205

BLOOMSBURG
Bloomsburg Hospital 125

BLOSSBURG
*Blossburg State Hospital 77

BRADDOCK
Braddock General Hospital 137

BRADFORD
Bradford Hospital 100

BROWNSVILLE
Brownsville General Hospital 100

BRYN MAWR
Bryn Mawr Hospital 262

CANONSBURG
Canonsburg General Hospital 54

CARLISLE
Carlisle Hospital 50

CHAMBERSBURG
Chambersburg Hospital 90

CHESTER
Chester Hospital 266
J. Lewis Crozer Homeopathic Hospital 100

CLEARFIELD
Clearfield Hospital 130

COALDALE
*Coaldale State Hospital 82

COATESVILLE
Coatesville Hospital 125
Veterans' Administration Hospital 483

COLUMBIA
*Columbia Hospital 75

CONNELLSVILLE
Connellsville State Hospital 106

CORRY
*Corry Hospital 48

DANVILLE
George F. Geisinger Memorial Hospital 180

DREXEL HILL
Delaware County Hospital 70

DU BOIS
Du Bois Hospital 50
Maple Avenue Hospital 70

EASTON
Easton Hospital 171

ERIE
Hamot Hospital 210
St. Vincent's Hospital 214

FRANKLIN
*Franklin Hospital 57

GETTYSBURG
Annie M. Warner Hospital 60

GREENSBURG
Westmoreland Hospital 160

HANOVER
Hanover General Hospital 65

HARRISBURG
Harrisburg Hospital 239
Harrisburg Polyclinic Hospital 182

HAZLETON
Hazleton State Hospital 135

HOMESTEAD
Homestead Hospital 118

HUNTINGDON
J. C. Blair Memorial Hospital 81

INDIANA
Indiana Hospital 85

JOHNSTOWN
Cambria Hospital 65
Conemaugh Valley Memorial Hospital 290
Lee Homeopathic Hospital 60
Mercy Hospital of Johnstown 100

KANE
Community Hospital 65
*Kane Summit Hospital 87

KINGSTON
Nesbitt Memorial Hospital 126

LANCASTER
Lancaster General Hospital 265
St. Joseph's Hospital 200

LEAGUE ISLAND
United States Naval Hospital 729

LEBANON
Good Samaritan Hospital 100

LEWISTOWN
Lewistown Hospital 87

LOCK HAVEN
Lock Haven Hospital 90

MAYVIEW
Pittsburgh City Home and Hospitals 3200

McKEESPORT
McKeesport Hospital 263

McKEES ROCKS
Ohio Valley General Hospital 86

MEADVILLE
Spencer Hospital 115

NANTICOKE
Nanticoke State Hospital 95

NEW BRIGHTON
Beaver Valley General Hospital 80

NEW CASTLE
Jameson Memorial Hospital 151
New Castle Hospital 125

NEW EAGLE
Memorial Hospital of Monongahela 73

NEW KENSINGTON
Citizens General Hospital 100

NORRISTOWN
Montgomery Hospital 125

OIL CITY
Oil City General Hospital 140

PALMERTON
Palmerton Hospital 65

PHILADELPHIA
- American Hospital for Diseases of the Stomach 39
- American Oncologic Hospital 45
- Broad Street Hospital 110
- Chestnut Hill Hospital 112
- Children's Hospital of Philadelphia 117
- Children's Hospital of the Mary J. Drexel Home 52
- Frankford Hospital 142
- Garretson Hospital of Temple University 80
- Germantown Dispensary and Hospital 360
- Graduate Hospital of the University of Pennsylvania 500
- Hahnemann Medical College Hospital 700
- Hospital Lankenau 298
- Hospital of the Protestant Episcopal Church in Philadelphia 450
- Hospital of the University of Pennsylvania 567
- Hospital of the Woman's Medical College of Pennsylvania 171
- Jeanes Hospital 72
- Jefferson Hospital 688
- Jewish Hospital 427
- Joseph Price Memorial Hospital 60
- Kensington Hospital for Women 101
- Memorial Hospital 115
- Mercy Hospital 100
- Methodist Episcopal Hospital 305
- Misericordia Hospital 306
- Mount Sinai Hospital 316
- Northeastern Hospital of Philadelphia 100
- Northern Liberties Hospital 69
- Northwestern General Hospital 64
- Pennsylvania Hospital 560
- Philadelphia General Hospital 2000
- Philadelphia Orthopaedic Hospital and Infirmary for Nervous Diseases 140
- Presbyterian Hospital in Philadelphia 333
- St. Agnes Hospital 346
- St. Christopher's Hospital for Children 75
- St. Joseph's Hospital 270
- St. Luke's and Children's Homeopathic Hospitals 300
- St. Mary's Hospital 210
- St. Vincent's Hospital for Women and Children 174
- Shriners' Hospital for Crippled Children 120
- Stetson Hospital 78
- Temple University Hospital 370
- Veterans' Administration Hospital 416
- Wills Hospital 126
- Woman's Hospital of Philadelphia 170
- Women's Homeopathic Hospital of Philadelphia 200

PHILIPSBURG
- Philipsburg State Hospital 108

PITTSBURGH
- Allegheny General Hospital 405
- Children's Hospital of Pittsburgh 200
- Elizabeth Steel Magee Hospital 395
- Eye and Ear Hospital 55
- Homeopathic Medical and Surgical Hospital and Dispensary 312
- Mercy Hospital 670
- Montefiore Hospital Association of Western Pennsylvania 225
- Passavant Hospital 150
- Pittsburgh Hospital 200
- Presbyterian Hospital 197
- Roselia Foundling Asylum and Maternity Hospital 215
- St. Francis Hospital 500
- St. John's General Hospital of Allegheny City 202
- St. Joseph's Hospital and Dispensary 140
- St. Margaret Memorial Hospital 152
- South Side Hospital 225
- Tuberculosis League Hospital 150
- United States Marine Hospital 92
- Western Pennsylvania Hospital 651

PITTSTON
- Pittston Hospital 125

POTTSTOWN
- Pottstown Hospital 100

POTTSVILLE
- Pottsville Hospital 140

READING
- Homeopathic Medical and Surgical Hospital 115
- Reading Hospital 268
- St. Joseph's Hospital 205

RIDLEY PARK
- Taylor Hospital 129

ROARING SPRING
- *Nason Hospital 58

ROCHESTER
- Rochester General Hospital 112

SAYRE
- Robert Packer Hospital 275

SCRANTON
- Hahnemann Hospital 125
- Mercy Hospital 110
- Moses Taylor Hospital 113
- St. Joseph's Children's and Maternity Hospital 188
- Scranton State Hospital 194

SELLERSVILLE
- Grand View Hospital 65

SEWICKLEY
- Valley Hospital 130

SHAMOKIN
- Shamokin State Hospital 100

SHARON
- Christian H. Buhl Hospital 125

TARENTUM
- Allegheny Valley Hospital 100

UNIONTOWN
- Uniontown Hospital 225

WARREN
- Warren General Hospital 102

WASHINGTON
- Washington Hospital 162

WAYNESBORO
- *Waynesboro Hospital 46

WEST CHESTER
- Chester County Hospital 136
- Homeopathic Hospital of Chester County 77

WILKES-BARRE
- Mercy Hospital 220
- Wilkes-Barre General Hospital 472

WILKINSBURG
- Columbia Hospital 204

WILLIAMSPORT
- Williamsport Hospital 275

WINDBER
- Windber Hospital 102

YORK
- West Side Sanitarium 50
- York Hospital 189

RHODE ISLAND

NEWPORT
- Newport Hospital 171
- United States Naval Hospital 295

PAWTUCKET
- Memorial Hospital 110

PROVIDENCE
- Charles V. Chapin Hospital 265
- Homeopathic Hospital of Rhode Island 200
- Miriam Hospital 77
- Providence Lying-in Hospital 310
- Rhode Island Hospital 600
- St. Joseph's Hospital 205

WESTERLY
- Westerly Hospital 73

WOONSOCKET
- *Woonsocket Hospital 136

SOUTH CAROLINA

ANDERSON
- Anderson County Hospital 84

BENNETTSVILLE
- Marlboro County General Hospital 43

CHARLESTON
- Baker Sanatorium 55
- Roper Hospital 325
- St. Francis Xavier Infirmary 62
- United States Naval Hospital 75

COLUMBIA
- Columbia Hospital of Richland County 125
- South Carolina Baptist Hospital 115

FLORENCE
- McLeod Infirmary 135
- *Saunders Memorial Hospital 50

GREENVILLE
- Greenville City Hospital 141
- Shriners' Hospital for Crippled Children 60

ORANGEBURG
- Orangeburg Hospital 57

PARRIS ISLAND
- United States Naval Hospital 161

SPARTANBURG
- Mary Black Clinic and Private Hospital 40
- Spartanburg General Hospital 273

SUMTER
- Tuomey Hospital 92

TAYLORS
- Chick Springs Hotel—Sanitarium 80

SOUTH DAKOTA

ABERDEEN
- St. Luke's Hospital 128

CHAMBERLAIN
- Chamberlain Sanitarium and Hospital 80

DEADWOOD
- St. Joseph's Hospital 50

HOT SPRINGS
- Veterans' Administration Hospital 207

HURON
- Sprague Hospital 57

LEAD
- Homestake Hospital 30

MADISON
- New Madison Hospital 75

MITCHELL
- Methodist State Hospital 115
- St. Joseph's Hospital 85

PIERRE
- St. Mary's Hospital 68

RAPID CITY
- Black Hills Methodist Hospital 60
- St. John's Hospital 87

SIOUX FALLS
- McKennan Hospital 125
- *Moe Hospital 48
- Sioux Valley Hospital 144

WATERTOWN
- Bartron Hospital 65
- Luther Hospital 68

WEBSTER
- Peabody Hospital 68

YANKTON
- Sacred Heart Hospital 150

TENNESSEE

BOLIVAR
- Western State Hospital 1200

CHATTANOOGA
- Baroness Erlanger Hospital 222
- Children's Hospital 84
- Newell and Newell Sanitarium 65
- Pine Breeze Sanitarium 225

DYERSBURG
- Baird-Brewer General Hospital 50

GREENEVILLE
- Greeneville Sanatorium and Hospital 62

JACKSON
- *Crook Sanatorium 41
- *Memorial Hospital 30

JOHNSON CITY
- Appalachian Hospital 58
- Veterans' Administration Hospital 769

KNOXVILLE
- Fort Sanders Hospital 147
- Knoxville General Hospital 281
- St. Mary's Memorial Hospital 82

MADISON
- Madison Rural Sanitarium 100

MEMPHIS
- Baptist Memorial Hospital 400
- Gartly-Ramsay Hospital 50
- Hospital for Crippled Adults 75
- Memphis Eye, Ear, Nose, and Throat Hospital 65
- Memphis General Hospital 400
- Methodist Hospital 180
- St. Joseph's Hospital 260
- United States Marine Hospital 65
- Veterans' Administration Hospital 470
- Willis C. Campbell Clinic Hospital 50

MURFREESBORO
- Rutherford Hospital 50

NASHVILLE
- Barr Infirmary 25
- George W. Hubbard Hospital 150
- Millie E. Hale Hospital 60
- Nashville General Hospital 150
- Protestant Hospital 110
- St. Thomas Hospital 225
- Vanderbilt University Hospital 215

TEXAS

ABILENE
- West Texas Baptist Sanitarium 50

AMARILLO
- Northwest Texas Hospital 85
- St. Anthony's Sanitarium 100

AUSTIN
- Seton Infirmary 100

BEAUMONT
- Beaumont General Hospital 85
- Hotel Dieu 150

BIG SPRINGS
- Bivings and Barcus Hospital 25

BROWNWOOD
- Medical Arts Hospital 40

CORPUS CHRISTI
- Fred Roberts Memorial Hospital 72
- Spohn Sanitarium 56

CUERO
- Burns Hospital 38

DALLAS
- Baylor University Hospital 332
- Bradford Memorial Hospital for Babies 60
- Dallas Medical and Surgical Clinic Hospital 27
- Dallas Methodist Hospital 100
- Parkland Hospital 295
- Rushing Clinic and Sanitarium 27
- St. Paul's Hospital 300
- Texas Scottish Rite Hospital for Crippled Children 40

DENISON
- *Missouri, Kansas and Texas Railroad Employes' Hospital 50

EL PASO
- *El Paso City-County Hospital 130
- El Paso Masonic Hospital 62
- Hotel Dieu Sisters' Hospital 123
- William Beaumont General Hospital 506

FORT SAM HOUSTON
- Station Hospital 750

FORT WORTH
- All Saints Hospital 90
- *Baptist Hospital of Fort Worth 60
- *City and County Hospital 134
- Harris Clinic-Hospital 100
- Methodist Hospital of Fort Worth 116
- St. Joseph's Infirmary 224
- W. I. Cook Memorial Hospital 53

GALVESTON
- John Sealy Hospital 388
- St. Mary's Infirmary 150
- United States Marine Hospital 100

HILLSBORO
*Boyd Sanitarium 25
HOUSTON
Hermann Hospital 196
Jefferson Davis Hospital 160
Memorial Hospital 192
Methodist Hospital 97
St. Joseph's Infirmary 225
Southern Pacific Hospital 148
JACKSONVILLE
Nan Travis Hospital 43
LAREDO
Mercy Hospital 90
LEGION
Veterans' Administration Hospital 480
LUBBOCK
*Lubbock Sanitarium 111
*West Texas Hospital 66
MARLIN
Torbett Sanatorium and Clinic 50
MARSHALL
Texas and Pacific Railway Employes' Hospital 105
McKINNEY
McKinney City Hospital 40
MINERAL WELLS
*Nazareth Hospital 40
ORANGE
*Frances Ann Lutcher Hospital 65
PALESTINE
International and Great Northern Railway Employes' Hospital 75
PARIS
St. Joseph's Infirmary 46
Sanitarium of Paris 69
PORT ARTHUR
St. Mary's Hospital, Gates Memorial 160
PRAIRIE VIEW
*Prairie View Hospital 50
SAN ANGELO
*St. John's Hospital 38
*Shannon West Texas Memorial Hospital 67
SAN ANTONIO
Medical and Surgical Hospital 115
Nix Hospital 184
Robert B. Green Memorial Hospital 235
Santa Rosa Hospital 342
SANTA ANNA
Sealy Hospital 38
SHERMAN
St. Vincent's Sanitarium 81
*Wilson N. Jones Hospital 74
SLATON
*Mercy Hospital 56
TEMPLE
Gulf, Colorado and Santa Fe Hospital 150
King's Daughters' Hospital 115
Scott and White Hospital 200
TEXARKANA
Texarkana Hospital 56
WACO
Central Texas Baptist Sanitarium 100
Colgin Hospital and Clinic 43
Providence Sanitarium 150
Veterans' Administration Hospital 308
WAXAHACHIE
Waxahachie Sanitarium 30
WICHITA FALLS
Wichita Falls Clinic-Hospital 80
Wichita General Hospital 138

UTAH

LOGAN
William Budge Memorial Hospital 60
OGDEN
Thomas D. Dee Memorial Hospital 185
SALT LAKE CITY
Dr. W. H. Groves Latter Day Saints Hospital 466
Holy Cross Hospital 65
St. Mark's Hospital 156
Salt Lake General Hospital 211
Veterans' Administration Hospital 103

VERMONT

BARRE
*Barre City Hospital 50
BRATTLEBORO
Brattleboro Memorial Hospital 60
BURLINGTON
Bishop de Goesbriand Hospital 122
Mary Fletcher Hospital 145
MIDDLEBURY
Porter Hospital 56
MONTPELIER
Heaton Hospital 77
RUTLAND
Rutland Hospital 120
ST. ALBANS
St. Albans Hospital 50
ST. JOHNSBURY
Brightlook Hospital 65
WINOOSKI
Fanny Allen Hospital 83

VIRGINIA

ABINGDON
George Ben Johnston Memorial Hospital 66
CLIFTON FORGE
Chesapeake and Ohio Hospital 110
DANVILLE
*Memorial Hospital 110
FARMVILLE
Southside Community Hospital 58
HAMPTON
Hampton Training School for Nurses and Dixie Hospital 75
Veterans' Administration Hospital 810
LYNCHBURG
Lynchburg Hospital 99
Marshall Lodge Memorial Hospital 130
Virginia Baptist Hospital 116
NEWPORT NEWS
Elizabeth Buxton Hospital 95
Riverside Hospital 72
NORFOLK
Hospital of St. Vincent de Paul 250
Memorial Hospital of Norfolk 58
Norfolk Protestant Hospital 160
Sarah Leigh Hospital 80
United States Marine Hospital 217
United States Naval Hospital 800
PETERSBURG
Medical Center-Central State Hospital 108
Petersburg Hospital 75
PORTSMOUTH
King's Daughters' Hospital 80
Parrish Memorial Hospital 60
RICHMOND
Crippled Children's Hospital 60
Grace Hospital 105
Johnston-Willis Hospital 127
Medical College of Virginia, the Memorial, the Dooley and St. Philip Hospitals 436
Retreat for the Sick 100
St. Elizabeth's Hospital 54
St. Luke's Hospital 81
Sheltering Arms Hospital 75
Stuart Circle Hospital 107
Tucker Sanatorium 52
ROANOKE
*Burrell Memorial Hospital 44
Gill Memorial Eye, Ear and Throat Hospital 25
Jefferson Hospital 100
Lewis-Gale Hospital 66
Roanoke Hospital 110
Shenandoah Hospital 60
STAUNTON
King's Daughters' Hospital 78
SUFFOLK
Lakeview Hospital 65
UNIVERSITY
University of Virginia Hospital 340
WINCHESTER
Winchester Memorial Hospital 125

WASHINGTON

ABERDEEN
Grays Harbor Hospital 76
St. Joseph's Hospital 76
AMERICAN LAKE
Veterans' Administration Hospital 676
BELLINGHAM
St. Joseph's Hospital 100
St. Luke's Hospital 100
BREMERTON, Puget Sound
United States Naval Hospital 254
CHEHALIS
*St. Helen's Hospital 43
COLFAX
*St. Ignatius Hospital 79
ELLENSBURG
Ellensburg General Hospital 50
EVERETT
General Hospital of Everett 100
Providence Hospital 125
OLYMPIA
St. Peter's Hospital 100
PASCO
Our Lady of Lourdes Hospital 52
PORT ANGELES
Port Angeles Hospital and Sanitarium 84
PORT TOWNSEND
United States Marine Hospital 100
SEATTLE
Children's Orthopedic Hospital 132
Columbus Hospital 200
Harborview Hospital 450
Martha Washington Hospital 135
Providence Hospital 412
St. Luke's Hospital 60
Seattle General Hospital 135
Swedish Hospital 255
Virginia Mason Hospital 180
SHELTON
*Shelton General Hospital 36
SPOKANE
Deaconess Hospital 205
Sacred Heart Hospital 330
St. Luke's Hospital 203
Shriners' Hospital for Crippled Children —Mobile Unit 25
TACOMA
Northern Pacific Beneficial Association Hospital 116
Pierce County Hospital 172
St. Joseph's Hospital 350
Tacoma General Hospital 200
U. S. Tacoma Hospital 250
VANCOUVER
Clark General Hospital 62
St. Joseph's Hospital 125
WALLA WALLA
St. Mary's Hospital 90
Veterans' Administration Hospital 355
Walla Walla Sanitarium and Hospital 50
WENATCHEE
Central Washington Deaconess Hospital 65
St. Anthony's Hospital 60
YAKIMA
St. Elizabeth's Hospital 183

WEST VIRGINIA

BECKLEY
Beckley Hospital 175
BLUEFIELD
Bluefield Sanitarium 115
St. Luke's Hospital 83
CHARLESTON
Kanawha Valley Hospital 92
McMillan Hospital 100
Mountain State Hospital 116
New Charleston General Hospital 160
CLARKSBURG
Mason Hospital 62
St. Mary's Hospital 143
ELKINS
Davis Memorial Hospital 76
Elkins City Hospital 65
FAIRMONT
*Cook Hospital 120
Fairmont Emergency Hospital 86
GLENDALE
Reynolds Memorial Hospital 90
HOPEMONT
*Hopemont Sanitarium 420
HUNTINGTON
Chesapeake and Ohio Hospital 110
Huntington Memorial Hospital 150
St. Mary's Hospital 100
LAKIN
*Lakin State Hospital 450
LOGAN
Hatfield-Lawson Hospital 105
MARTINSBURG
City Hospital 50
*King's Daughters' Hospital 65
MONTGOMERY
Coal Valley Hospital 65
MORGANTOWN
*Monongalia County Hospital 82
OAK HILL
Oak Hill Hospital 50
PARKERSBURG
*Camden-Clark Hospital 78
*St. Joseph's Hospital 150
PRINCETON
Mercer Memorial Hospital 51
RONCEVERTE
Greenbrier Valley Hospital 53
WELCH
Stevens Clinic Hospital 80
Welch Emergency Hospital 115
WHEELING
Ohio Valley General Hospital 275
Wheeling Hospital 185

WISCONSIN

APPLETON
St. Elizabeth Hospital 250
ASHLAND
*Ashland General Hospital 75
St. Joseph's Hospital 167
BELOIT
Beloit Municipal Hospital 100
DODGEVILLE
St. Joseph's Hospital 72
EAU CLAIRE
Luther Hospital 167
FOND DU LAC
St. Agnes Hospital 250
GREEN BAY
Bellin Memorial Hospital 100
St. Mary's Hospital 126
JANESVILLE
Mercy Hospital 150
KENOSHA
Kenosha Hospital 180
St. Catherine's Hospital 65
LA CROSSE
Grandview Hospital 116
La Crosse Hospital 46
La Crosse Lutheran Hospital 149
St. Francis Hospital 355
MADISON
Madison General Hospital 180
Methodist Hospital 120
St. Mary's Hospital 180
State of Wisconsin General Hospital 630
Wisconsin Orthopedic Hospital for Children 120
MANITOWOC
Holy Family Hospital 150
MARSHFIELD
St. Joseph's Hospital 170
MILWAUKEE
Columbia Hospital 141
Evangelical Deaconess Hospital 182

Johnston Emergency Hospital 29
Milwaukee Children's Hospital 150
Milwaukee General Hospital 200
Milwaukee Hospital 270
Misericordia Hospital 150
Mount Sinai Hospital 170
Sacred Heart Sanitarium 445
St. Joseph's Hospital 325
St. Luke's Hospital 118
St. Mary's Hospital 266
Veterans' Administration Hospital 1262

NEENAH
Theda Clark Memorial Hospital 72

OSHKOSH
Mercy—St. Mary's Hospital 192

RACINE
St. Luke's Hospital 158
St. Mary's Hospital 117

STEVENS POINT
St. Michael's Hospital 139

SUPERIOR
St. Mary's Hospital 116

WAUSAU
St. Mary's Hospital 130
Wausau Memorial Hospital 110

WAUWATOSA
Milwaukee County Hospital 1050
Muirdale Sanatorium 375

WYOMING

CASPER
Memorial Hospital of Natrona County 115

CHEYENNE
Memorial Hospital of Laramie County 152

MIDWEST
Midwest Hospital 25

SHERIDAN
Sheridan County Memorial Hospital 72
Veterans' Administration Hospital 438

WHEATLAND
Wheatland General Hospital 69

ALASKA

FORT YUKON
Hudson Stuck Memorial Hospital 40

CANAL ZONE

ANCON
Gorgas Hospital 874

HAWAII

HILO
Hilo Memorial Hospital 92

HONOLULU
*Japanese Hospital 120
*Kauikeolani Children's Hospital 61
Leahi Home 450
Queen's Hospital 284
St. Francis Hospital 55
Shriners' Hospital for Crippled Children 34

PANAMA

PANAMA
Hospital Santo Tomas 892

PORTO RICO

SAN JUAN
Presbyterian Hospital 70

ARMY

DENVER, COLORADO
Fitzsimons General Hospital 1848

EL PASO, TEXAS
William Beaumont Hospital 403

FORT SAM HOUSTON, TEXAS
Station Hospital 800

SAN FRANCISCO, CALIFORNIA
Letterman General Hospital 750

WASHINGTON, DIST. OF COLUMBIA
Walter Reed General Hospital 1500

NAVY

ANNAPOLIS, MARYLAND
United States Naval Hospital 252

BREMERTON, WASHINGTON
United States Naval Hospital 254

CHARLESTON, SOUTH CAROLINA
United States Naval Hospital 75

CHELSEA, MASSACHUSETTS
United States Naval Hospital 628

GREAT LAKES, ILLINOIS
United States Naval Hospital 800

LEAGUE ISLAND, PHILADELPHIA, PENNSYLVANIA
United States Naval Hospital 500

MARE ISLAND, CALIFORNIA
United States Naval Hospital 721

NEWPORT, RHODE ISLAND
United States Naval Hospital 295

NEW YORK, NEW YORK
United States Naval Hospital 847

NORFOLK, VIRGINIA
United States Naval Hospital 816

PARRIS ISLAND, SOUTH CAROLINA
United States Naval Hospital 161

PENSACOLA, FLORIDA
United State Naval Hospital 190

PORTSMOUTH, NEW HAMPSHIRE
United States Naval Hospital 166

SAN DIEGO, CALIFORNIA
United States Naval Hospital 1000

SAN PEDRO, CALIFORNIA
United States Naval Hospital Ship Relief 317

WASHINGTON, DISTRICT OF COLUMBIA
United States Naval Hospital 427

PUBLIC HEALTH

BALTIMORE, MARYLAND
United States Marine Hospital 167

BUFFALO, NEW YORK
United States Marine Hospital 85

CARVILLE, LOUISIANA
United States Marine Hospital 372

CHELSEA, MASSACHUSETTS
United States Marine Hospital 167

CHICAGO, ILLINOIS
United States Marine Hospital 150

CLEVELAND, OHIO
United States Marine Hospital 250

DETROIT, MICHIGAN
United States Marine Hospital 132

ELLIS ISLAND, NEW YORK
United States Marine Hospital 540

EVANSVILLE, INDIANA
United States Marine Hospital 54

FORT STANTON, NEW MEXICO
United States Marine Hospital 270

GALVESTON, TEXAS
United States Marine Hospital 100

KEY WEST, FLORIDA
United States Marine Hospital 112

LOUISVILLE, KENTUCKY
United States Marine Hospital 83

MEMPHIS, TENNESSEE
United States Marine Hospital 65

MOBILE, ALABAMA
United States Marine Hospital 90

NEW ORLEANS, LOUISIANA
United States Marine Hospital 569

NORFOLK, VIRGINIA
United States Marine Hospital 217

PITTSBURGH, PENNSYLVANIA
United States Marine Hospital 92

PORTLAND, MAINE
United States Marine Hospital 72

PORT TOWNSEND, WASHINGTON
United States Marine Hospital 100

ST. LOUIS, MISSOURI
United States Marine Hospital 100

SAN FRANCISCO, CALIFORNIA
United States Marine Hospital 472

SAVANNAH, GEORGIA
United States Marine Hospital 150

STAPLETON, NEW YORK
United States Marine Hospital 288

VINEYARD HAVEN, MASSACHUSETTS
United States Marine Hospital 25

VETERANS' ADMINISTRATION

ALBUQUERQUE, NEW MEXICO
Veterans' Administration Hospital 259

ALEXANDRIA, LOUISIANA
Veterans' Administration Hospital 439

AMERICAN LAKE, WASHINGTON
Veterans' Administration Hospital 676

ASPINWALL, PENNSYLVANIA
Veterans' Administration Hospital 269

ATLANTA, GEORGIA
Veterans' Administration Hospital 200

AUGUSTA, GEORGIA
Veterans' Administration Hospital 755

AUGUSTA, MAINE
Veterans' Administration Hospital 324

BATH, NEW YORK
Veterans' Administration Hospital 395

BEDFORD, MASSACHUSETTS
Veterans' Administration Hospital 644

BOISE, IDAHO
Veterans' Administration Hospital 206

BRONX, NEW YORK
Veterans' Administration Hospital 950

CAMP CUSTER, MICHIGAN
Veterans' Administration Hospital 774

CANANDAIGUA, NEW YORK
Veterans' Administration Hospital 468

CASTLE POINT, NEW YORK
Veterans' Administration Hospital 479

CHILLICOTHE, OHIO
Veterans' Administration Hospital 614

COATESVILLE, PENNSYLVANIA
Veterans' Administration Hospital 483

DANVILLE, ILLINOIS
Veterans' Administration Hospital 560

DAYTON, OHIO
Veterans' Administration Hospital 1105

DWIGHT, ILLINOIS
Veterans' Administration Hospital 225

EXCELSIOR SPRINGS, MISSOURI
Veterans' Administration Hospital 252

FARGO, NORTH DAKOTA
Veterans' Administration Hospital 57

FORT BAYARD, NEW MEXICO
Veterans' Administration Hospital 450

FORT HARRISON, MONTANA
Veterans' Administration Hospital 306

FORT LYON, COLORADO
Veterans' Administration Hospital 589

GULFPORT, MISSISSIPPI
Veterans' Administration Hospital 598

HAMPTON, VIRGINIA
Veterans' Administration Hospital 810

HINES, ILLINOIS
Veterans' Administration Hospital 1750

HOT SPRINGS, SOUTH DAKOTA
Veterans' Administration Hospital 297

INDIANAPOLIS, INDIANA
Veterans' Administration Hospital 152

JEFFERSON BARRACKS, MISSOURI
Veterans' Administration Hospital 372

JOHNSON CITY, TENNESSEE
Veterans' Administration Hospital 769

KANSAS CITY, MISSOURI
Veterans' Administration Hospital 200

KNOXVILLE, IOWA
Veterans' Administration Hospital 851

LAKE CITY, FLORIDA
Veterans' Administration Hospital 397

LEAVENWORTH, KANSAS
Veterans' Administration Hospital 448

LEGION, TEXAS
Veterans' Administration Hospital 480

LEXINGTON, KENTUCKY
Veterans' Administration Hospital 250

LINCOLN, NEBRASKA
Veterans' Administration Hospital 197

LIVERMORE, CALIFORNIA
Veterans' Administration Hospital 318

LOS ANGELES, CALIFORNIA
Veterans' Administration Hospital 857

LYONS, NEW JERSEY
Veterans' Administration Hospital 895

MARION, INDIANA
Veterans' Administration Hospital 1400

MEMPHIS, TENNESSEE
Veterans' Administration Hospital 470

MILWAUKEE, WISCONSIN
Veterans' Administration Hospital 1262

MINNEAPOLIS (FORT SNELLING), MINNESOTA
Veterans' Administration Hospital 554

MUSKOGEE, OKLAHOMA
Veterans' Administration Hospital 400

NEWINGTON, CONNECTICUT
Veterans' Administration Hospital 266

NORTHAMPTON, MASSACHUSETTS
Veterans' Administration Hospital 555

NORTH CHICAGO, ILLINOIS
Veterans' Administration Hospital 1135

NORTH LITTLE ROCK, ARKANSAS
Veterans' Administration Hospital 820

NORTHPORT, L. I., NEW YORK
Veterans' Administration Hospital 1392

OTEEN, NORTH CAROLINA
Veterans' Administration Hospital 612

OUTWOOD, KENTUCKY
Veterans' Administration Hospital 375

PALO ALTO, CALIFORNIA
Veterans' Administration Hospital 1010

PERRY POINT, MARYLAND
Veterans' Administration Hospital 1015

PHILADELPHIA, PENNSYLVANIA
Veterans' Administration Hospital 416

PORTLAND, OREGON
Veterans' Administration Hospital 337

RUTLAND HEIGHTS, MASSACHUSETTS
Veterans' Administration Hospital 420

SALT LAKE CITY, UTAH
Veterans' Administration Hospital 103

SAN FERNANDO, CALIFORNIA
Veterans' Administration Hospital 230

SHERIDAN, WYOMING
Veterans' Administration Hospital 438

ST. CLOUD, MINNESOTA
Veterans' Administration Hospital 494

SUNMOUNT, NEW YORK
Veterans' Administration Hospital 380

TUCSON, ARIZONA
Veterans' Administration Hospital 358

TUSCALOOSA, ALABAMA
Veterans' Administration Hospital 273

TUSKEGEE, ALABAMA
Veterans' Administration Hospital 804

WACO, TEXAS
Veterans' Administration Hospital 308

WALLA WALLA, WASHINGTON
Veterans' Administration Hospital 355

WASHINGTON, DISTRICT OF COLUMBIA
Veterans' Administration Hospital 260

WHIPPLE, ARIZONA
Veterans' Administration Hospital 600

ALBERTA

BANFF
Banff Mineral Springs Hospital 61

CALGARY
Calgary General Hospital 214
Colonel Belcher Hospital 180
Holy Cross Hospital 300

CAMROSE
St. Mary's Hospital 50

DRUMHELLER
Drumheller Municipal Hospital 92

EDMONTON
Edmonton General Hospital 200
Misericordia Hospital 175
Royal Alexandra Hospital 410
University of Alberta Hospital 376

HANNA
*Hanna Municipal Hospital 64

UTILITY AND FLEXIBILITY

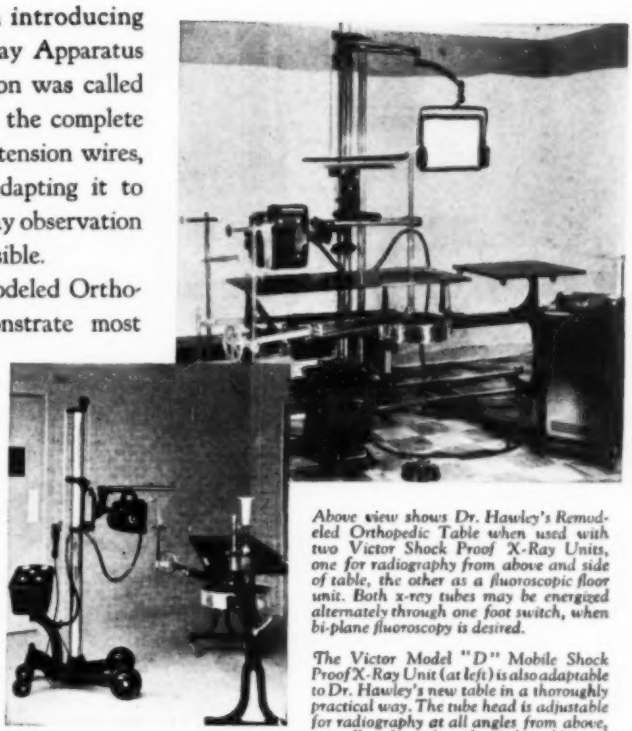
of Victor Shock Proof X-Ray Apparatus (Oil Immersed) demonstrated with Dr. Hawley's Remodeled Orthopedic Table

SEVERAL years ago when introducing Victor Shock Proof X-Ray Apparatus for medical diagnosis, attention was called to its great flexibility, due to the complete elimination of exposed high tension wires, and to the possibilities of adapting it to specialized work in which x-ray observation had proven difficult or impossible.

Dr. Hawley's recently remodeled Orthopedic Table serves to demonstrate most effectively how Victor Shock Proof X-Ray Apparatus may be utilized to overcome difficult problems of long standing, in the visual observation of fractures during actual manipulation and reduction.

From the fact that both the x-ray tube and high tension transformer are *immersed in oil* and sealed in a grounded, metal container (so-called tube head), the apparatus is absolutely shock proof. The x-ray tube may therefore be positioned according to the best vantage point, regardless of proximity to patient or surrounding equipment.

Result, fluoroscopic visualization during manipulation for reduction of fractures, with the surgeon and assistants in actual contact with the x-ray tube container if necessary, without fear or danger of shock from high tension. The close cooperation thus made possible in the field of operation is obviously a distinct aid in controlling and regulating manipulation and reduction.



Above view shows Dr. Hawley's Remodeled Orthopedic Table when used with two Victor Shock Proof X-Ray Units, one for radiography from above and side of table, the other as a fluoroscopic floor unit. Both x-ray tubes may be energized alternately through one foot switch, when bi-plane fluoroscopy is desired.

The Victor Model "D" Mobile Shock Proof X-Ray Unit (at left) is also adaptable to Dr. Hawley's new table in a thoroughly practical way. The tube head is adjustable for radiography at all angles from above, as well as from the side of the table, and may also be swung under the table for fluoroscopy.

When not in use with the fracture table, this mobile x-ray unit can be used in other parts of the hospital, such as the ward or operating room.

LAMONT
Lamont Public Hospital 75
LETHBRIDGE
Galt Hospital 96
St. Michael's Hospital 100
MEDICINE HAT
Medicine Hat General Hospital 151
RED DEER
Red Deer Municipal Hospital 35
STETTLER
*Stettler Municipal Hospital 36
VEGREVILLE
Vegreville General Hospital 46

BRITISH COLUMBIA

CRANBROOK
*St. Eugene Hospital 100
ESSONDALE
Provincial Mental Hospital 1946
KAMLOOPS
Royal Inland Hospital 150
KELOWNA
*Kelowna General Hospital 72
NEW WESTMINSTER
Royal Columbian Hospital 216
TRANQUILLE
Tranquille Sanatorium 330
VANCOUVER
Grace Hospital 140
St. Paul's Hospital 300
Shaughnessy Hospital 270
Vancouver General Hospital 1184
VICTORIA
Provincial Royal Jubilee Hospital 298
St. Joseph's Hospital 260

MANITOBA

BRANDON
Brandon General Hospital 205
NINETTE
Manitoba Sanatorium Hospital 290
ST. BONIFACE
St. Boniface Hospital 460
WINNIPEG
Children's Hospital of Winnipeg 136
Grace Hospital 247
Misericordia Hospital 235
Municipal Hospitals
King Edward Memorial Hospital
King George Hospital 360
St. Joseph's Hospital 125
Shriners' Hospital for Crippled Children —Mobile Unit 30
*Victoria Hospital 128
Winnipeg General Hospital 663

NEW BRUNSWICK

CAMPBELLTON
Hotel Dieu Hospital 106
Restigouche and Bay Chaleur Soldiers' Memorial Hospital 52
CHATHAM
Hotel Dieu Hospital 52
FREDERICTON
Victoria Public Hospital 75
MONCTON
Hotel Dieu de l'Assomption 125
Moncton Hospital 175
NEWCASTLE
Miramichi Hospital 56
ST. BASIL
Hotel Dieu of St. Joseph 58
SAINT JOHN
Lancaster Hospital 70
Saint John County Hospital 200
Saint John General Hospital 300
Saint John Infirmary 120
ST. STEPHEN
Chipman Memorial Hospital 77
TRACADIE
Hotel Dieu of St. Joseph 32
WOODSTOCK
*Carleton County L. P. Fisher Memorial Hospital 50

NOVA SCOTIA

AMHERST
Highland View Hospital 68
ANTIGONISH
St. Martha's Hospital 127
GLACE BAY
Glace Bay General Hospital 97
St. Joseph's Hospital 100
HALIFAX
Camp Hill Hospital 244
*Children's Hospital 55
Grace Maternity Hospital 105
Halifax Infirmary 65
Victoria General Hospital 260
KENTVILLE
Nova Scotia Sanatorium 355
NEW GLASGOW
Aberdeen Hospital 85
NEW WATERFORD
New Waterford General Hospital 57
SYDNEY
*St. Rita Hospital 50
Sydney City Hospital 68
SYDNEY MINES
*Harbor View Hospital 35
TRURO
Colchester County Hospital 47
YARMOUTH NORTH
*Yarmouth Hospital 70

ONTARIO

BRANTFORD
Brantford General Hospital 200
BROCKVILLE
*Brockville General Hospital 108
*St. Vincent de Paul Hospital 91
BYRON
Queen Alexandra Sanatorium 419
CHATHAM
Public General Hospital 100
St. Joseph's Hospital 92
CORNWALL
*Cornwall General Hospital 80
*Hotel Dieu Hospital 100
FORT WILLIAM
McKellar General Hospital 226
GALT
Galt General Hospital 78
GRAVENHURST
Muskoka Hospital for Consumptives 308
GUELPH
*St. Joseph's Hospital 104
HAMILTON
Hamilton General Hospital 570
Mountain Sanatorium 600
St. Joseph's Hospital 185
KINGSTON
Hotel Dieu Hospital 165
Kingston General Hospital 331
KITCHENER
St. Mary's Hospital 137
LONDON
St. Joseph's Hospital 253
Victoria Hospital 436
Westminster Hospital 540
NIAGARA FALLS
Niagara Falls General Hospital 60
OSHAWA
Oshawa General Hospital 94
OTTAWA
Ottawa Civic Hospital 660
Ottawa General Hospital 350
OWEN SOUND
General and Marine Hospital 108
PETERBORO
Nicholls Hospital 90
St. Joseph's Hospital 102
PORT ARTHUR
St. Joseph's General Hospital 162
ST. CATHARINES
St. Catharines General Hospital 185
ST. THOMAS
Memorial Hospital 110
SAULT STE. MARIE
General Hospital 90
SMITHS FALLS
*St. Francis General Hospital 50
*Smiths Falls Public Hospital 50
STRATFORD
Stratford General Hospital 125
SUDBURY
St. Joseph's Hospital 137
TORONTO
Christie Street Hospital 525
Grace Hospital Division of the Toronto Western Hospital 154
Hospital for Sick Children 374
Lockwood Clinic Hospital 50
Riverdale Isolation Hospital 399
St. Joseph's Hospital 150
St. Michael's Hospital 600
Toronto East General Hospital 134
Toronto General Hospital 955
Toronto Western Hospital 350
Wellesley Hospital 100
Women's College Hospital 80
WALKERVILLE
Metropolitan General Hospital 175
WESTON
Toronto Hospital for Consumptives 461
WINDSOR
Hotel Dieu of St. Joseph 132
Salvation Army Grace Hospital 124
WOODSTOCK
Woodstock General Hospital 65

PRINCE EDWARD ISLAND

CHARLOTTETOWN
Charlottetown Hospital 80
Prince Edward Island Hospital 60
SUMMERSIDE
Prince County Hospital 67

QUEBEC

LACHINE
*Lachine General Hospital 50
MONTREAL
Alexandra Hospital 155
Children's Memorial Hospital 200
Homeopathic Hospital of Montreal 115
Hopital de la Misericorde and Catholic Maternity 600
Hopital Sainte Jeanne D'Arc 211
Hopital Sainte Justine, Pour Les Enfants 340
Hotel Dieu de Saint Joseph 300
L'Hopital Notre Dame 316
Montreal Foundling and Baby Hospital 80
Montreal General Hospital, Central Division 400
Montreal General Hospital, Western Division 85
Royal Victoria—Montreal Maternity Hospital 750
*Sacred Heart Hospital 645
Shriners' Hospital for Crippled Children 60
Woman's General Hospital 225
QUEBEC
Hopital de l'Enfant Jesus 120
Hopital du Saint Sacrement 260
Hotel Dieu du Precieux Sang 260
Jeffery Hale Hospital 140
ST. ANNE DE BELLEVUE
St. Anne de Bellevue Hospital 650
STE. FOY
Hopital Laval 270
ST. HYACINTHE
*St. Charles Hospital 135
SHERBROOKE
Hopital General St. Vincent de Paul 250
Sherbrooke Hospital 90
TROIS RIVIERES
*Hopital St. Joseph 101

SASKATCHEWAN

CANORA
*Hugh Waddell Memorial Hospital 50
FORT QU' APPELLE
Fort Qu' Appelle Sanatorium 305
HUMBOLDT
St. Elizabeth's Hospital 79
MACKLIN
*St. Joseph's Hospital 60
MOOSE JAW
Moose Jaw General Hospital 180
Providence Hospital 98
NORTH BATTLEFORD
Notre Dame Hospital 57
PRINCE ALBERT
Holy Family Hospital 85
Prince Albert Sanatorium 220
Victoria Hospital 72
REGINA
Regina General Hospital 411
Regina Grey Nuns' Hospital 220
SASKATOON
City Hospital 227
St. Paul's Hospital 246
Saskatoon Sanatorium 165
TISDALE
*St. Therese Hospital 46

AUSTRALIA

NEW SOUTH WALES
Lewisham Hospital, Sydney
Newcastle Hospital, Newcastle
Royal Alexandra Hospital for Children, Camperdown, Sydney
Royal North Sydney Hospital, Sydney
Royal Prince Alfred Hospital, Camperdown, Sydney
St. Vincent's Hospital, Sydney
Sydney Hospital, Sydney
VICTORIA
Alfred Hospital, Melbourne
Austin Hospital, Melbourne
Children's Hospital, Melbourne
Melbourne Hospital, Melbourne
Queen's Memorial Hospital, Melbourne
St. Vincent's Hospital, Melbourne
Women's Hospital, Melbourne

CHINA

Peking Union Medical College Hospital, Peking

CUBA

Clinica Fortun-Souza, Havana
Francisco M. Fernandez Hospital, Havana
Instituto Del Cancer, Havana

FRANCE

American Hospital, Paris

NEWFOUNDLAND

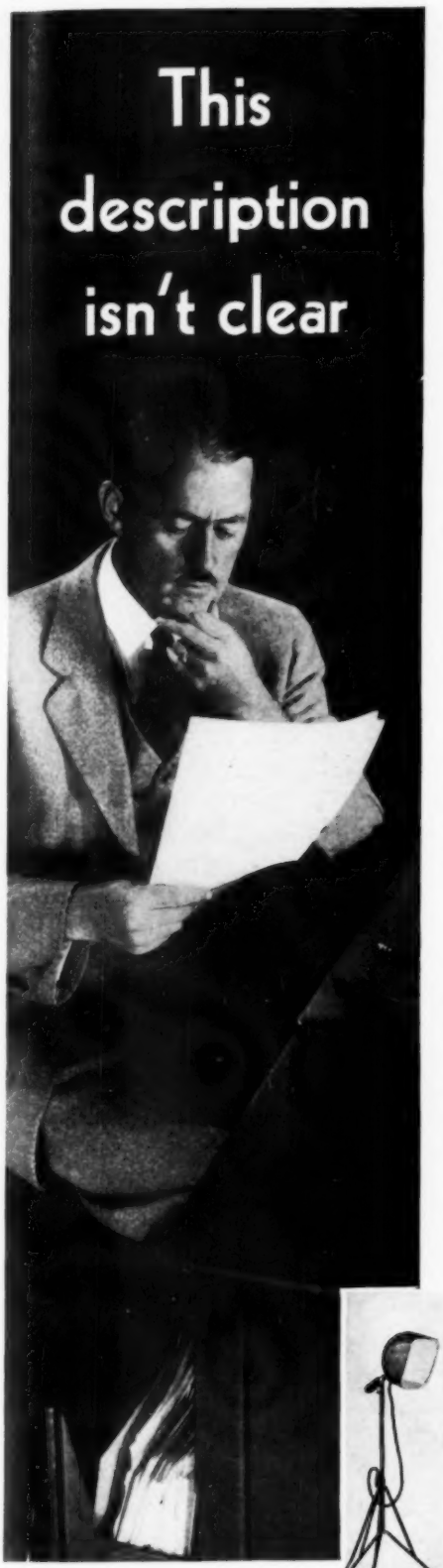
Notre Dame Bay Memorial Hospital, Twillingate
St. Anthony Hospital, St. Anthony

NEW ZEALAND

Auckland Hospital, Auckland
Cashmere Sanatorium, Christchurch
Christchurch Hospital, Christchurch
Dunedin Hospital, Dunedin
Wellington Hospital, Wellington

URUGUAY

Gynecological Hospital (Pereira Rossell), Montevideo
Maternity Hospital (Pereira Rossell), Montevideo



Words *vs.* Photos

WHEN they want to correlate cases . . . when they need material for instruction or the preparation of papers, or perhaps in medico-legal situations, the members of your staff turn to your file of case histories. If these records are adequately illustrated, the facts they obtain are clear and concise.

Words often are unwieldy in describing a condition accurately. But photographs clarify the records so that misinterpretation would be difficult. In effect they say, "Here are the facts —graphic, clear, convincing. Here is the gross specimen . . . here is a photomicrograph of a section . . . here is a copy of the radiograph." And years from now the evidence will still be fresh and undimmed. Files of such graphically illustrated case records add prestige to both the staff and the hospital.

Inexpensive routine

Clinical photography reaches the simplest possible routine with the Eastman Clinical Camera Outfit illustrated below. A few moments of a technician's time, and permanently vivid facts are added to the case records. The Outfit itself is inexpensive and its use entails but a few cents for each case.

• ABOVE, CENTER—*Eastman Clinical Camera and Kodalites. The complete outfit, consisting of the camera with Kodak Anastigmat Lens f.7.7 in No. 2 Kodamatic Shutter, Compact Stand with tilting top, Lantern Slide and Enlarging Backs, and two Model B Kodalites. $165.*

EASTMAN KODAK COMPANY, *Medical Division,*
343 State Street, Rochester, N. Y.

Gentlemen: Please send me your booklet describing the various phases of clinical photography.

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Institution_____

No. & St._____

City & State_____

NURSING AND THE HOSPITAL

Conducted by M. HELENA MCMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

The Nurse as an Educator—A Dual Rôle and an Exacting One

By ADELBERT A. THOMAS
New York City

ONE common objective of all nurses regardless of their specialized field is education—leading those with whom they come in contact from the old to the new way of living, changing not alone their habits but their attitudes, and substituting scientific truth for superstition, fact for fallacy. The hospital nurse no less than the public health nurse has countless opportunities to play the dual rôle of educator and nurse. The hospital, the clinic and the community offer endless situations for the use of her talents.

Many factors are involved in this problem and time is one of the most important. Think of the time it takes to displace an established habit in an adult. Infinite patience is needed and discouragement must be guarded against. After weeks of careful instruction by the nurse, there will still be mothers who insist on feeding their suckling infants on the ordinary diet of the family, and families who after repeated urgings to use the bathtub for bathing purposes fill it with the week's supply of coal or potatoes.

Tact and Diplomacy Are Essential

Constant concern for the welfare of others is likely to weary the most ardent of workers. There will and must be days of discouragement, but a fundamental belief that the job is worth while will make these periods relatively rare.

A practical knowledge of psychology and sociology is as fundamental a part of the nurse's equipment as her kit, and as useful in handling the difficult situations with which she is faced daily. This along with a real love for humanity will make her see Mrs. Jones as a person and not just a case. Whether that person is a fractious patient in a private ward or a harassed mother at home, the nurse's tact and diplomacy, like a magic sword, can serve to cut the Gordian knot of family difficulties.

As a person Mrs. Jones calls for carefully thought out plans. Each visit of the public health nurse to her home is a definite working out of objectives. They are not unrelated, but are a part of a well planned educational program for the Joneses.

We Learn by Seeing

With education as the objective the most commonplace acts become significant. The bath given in the hospital, the home or the clinic serves its purpose as a part of the program and not altogether as routine for the nurse. The patient may find the unusual cleanliness of the hospital attractive or repellent according to the interpretation of his nurse. His concept of cleanliness may be completely changed by his hospital experience, for there he has seen demonstrated some of the well established facts concerning the care of the sick, such as the importance of clean hands, of clean bedding, of clean dishes.

The nurse may forget that by her very presence she is teaching, but the things she has come to take for granted are new to many of those with whom she comes in contact. The starched uniform, the crisp white cuffs and collar, are an inspiration. Many of her patients strive to emulate her trim and immaculate appearance. The care with which she washes her hands, disposes of soiled material and guards against contamination, is observed and forms the basis for future action. We learn by personal example as well as by doing. As for Mrs. Jones who is taking care of her sick mother in her home, the routine bath becomes a

vital part of her education since she is allowed, even though it takes longer, to finish bathing the patient. Observation alone cannot take the place of actual participation.

The matter of personal appearance cannot be stressed too often or too strongly. A certain superintendent of public health nurses in a large city noticed that a member of her staff appeared morning after morning with soiled cuffs and collar. Finally in desperation the chief called her for a conference, warning her that if she failed to have clean cuffs and a clean collar another day her resignation would be expected. The next morning the nurse was starched, fresh and spotless, and never again was she guilty of her former carelessness. The superintendent later explained that it was her firm belief that patients lost both respect for and faith in the nurse whose appearance was anything but immaculate.

To the experienced worker no community is just a mass of people. The population is grouped according to her special problems or interests—mothers in the home comprise one group, while patients in hospitals, wage earners, preschool children and children of school age represent still others. These are the ones who are to be helped to find a better and perhaps easier way of life.

The group is invaluable for educational purposes. Modern education has repeatedly emphasized the value to be gained from group work. Clubs, parent-teacher associations, settlement groups, clinics, all offer the nurse the opportunity to present her ideas and information. She in turn benefits from the inspiration which comes with the knowledge that there are many interested in the solution of the same problem. One mother's problem becomes multiplied by ten or fifteen and the fire of zeal so necessary for the soul's content is rekindled.

Printed Matter Is Helpful

Since the dawn of history the educative process has been carried on largely through dramatics, and today as in all the yesterdays dramatics are used for educational purposes. Demonstrations are dramatizations. The nurse and the baby are the chief actors when mothers are being taught the proper way to bathe their babies. In the case of first aid, the patient is the star and the nurse and perhaps an assistant complete the cast. In the teaching of many techniques the use of dramatics will aid materially.

Health films offer another way of presenting material dramatically. Unfortunately with the advent of the sound picture it becomes increasingly difficult to get groups to sit through a silent health film—a task difficult enough at best. There is a glimmer of hope in this direction, however, and before many years some good sound pictures should be available in the field of public health.

For the present, perhaps the printed word is the chief prop in the public health education program. Too frequently, however, health literature is not written in language comprehensible to the average person. The nurse is faced with the problem of selecting from an array of tempting looking publications, those that are scientifically and educationally sound and that will at the same time be intelligible to Mrs. Jones. The newspaper also comes under this heading, and often presents a problem. The health advice it prints does not always conform to the latest and most authentic knowledge available. This is a real handicap since the printed word is still taken as solemn truth by the majority.

Let Others Share the Job

Epidemics often have genuine educational value. The most fruitful period for immunization against diphtheria, smallpox and typhoid fever frequently occurs during or following epidemics of these diseases. Although it may be fear that makes the public alive to the danger, the result is educational. At such a time the press can be a valued ally. Editorials and articles that stress the need for immunization and carry information concerning the need for cleanliness of the water and milk supplies, the simple though important procedures of the washing of hands, the care of the patients' dishes, the disposal of excreta and the observance of quarantine, are read avidly. It is during epidemics that the benefits of prevention are demonstrated.

Sharing the job is a part of the educational program. The more people are allowed to assist, the more they learn. Many nurses have won loyal support and understanding through the cooperation of lay members of the community. The job becomes "our job" and not "my job." Then, too, it is comforting to know that others realize the full import of what is being attempted. Men courageous enough, and deeply interested enough to mire their cars hub deep in mud to see the sanitary conditions of little one-room schools learn more about health and sanitary needs than they could from all the printed surveys on the subject.

One civic club attempted this sharing on a statewide basis and the results were remarkable. These men had forgotten some of the real things of life and although they contributed personally to the community fund that paid the nurse, they scarcely realized what her job was until they saw it with their own eyes. They learned best when their emotions became involved. Civic groups, both

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NOW, you can give patients the benefits of ultra-violet, and have good illumination, too. For the General Electric MAZDA Sunlight Lamp is the *only* lamp that gives adequate ultra-violet *plus* good light for general illumination.

The MAZDA Sunlight Lamp, developed and made by General Electric, is already being used in a number of hospitals, children's homes, schools, and similar public institutions as well as in thousands of homes. Fixtures for the use of these lamps can be either ceiling type, portable floor lamp or table lamp style. You can now bring ultra-violet to your patients in or out of bed, in wards or private rooms. And newly developed ceiling fixtures give you ultra-violet at the touch of a switch . . . general illumination without ultra-violet . . . or both at the same time. Mail coupon today for *free* descriptive booklet.

If you will send us dimensions of rooms in which you might want MAZDA Sunlight Lamps, indicating location of beds, we shall be glad to send you suggested plans and specifications for an installation, entirely without obligation to you.

"Hurrah! She has turned on the sun," cry the children in the Maryland General Hospital, Baltimore, when the nurse turns on the battery of MAZDA *Sunlight Lamps.*

Coupon brings your *free* copy of the booklet "The Indoor Sun." It tells of the value of sunshine and the benefits of vitamin D. Also gives details of the MAZDA Sunlight Lamps and fixtures. Clip coupon *now*.

Fixtures made by these manufacturers carry this approval seal

MAZDA Sunlight Lamps (some call them "bulbs") can *not* be screwed into an ordinary socket. They require special fixtures. Look for this seal when you buy a fixture. It indicates that a similar fixture has been submitted to the Nela Park Laboratories of the General Electric Company and that it has been tested and approved by them for illumination and ultra-violet effectiveness when used with the General Electric MAZDA Sunlight Lamp.

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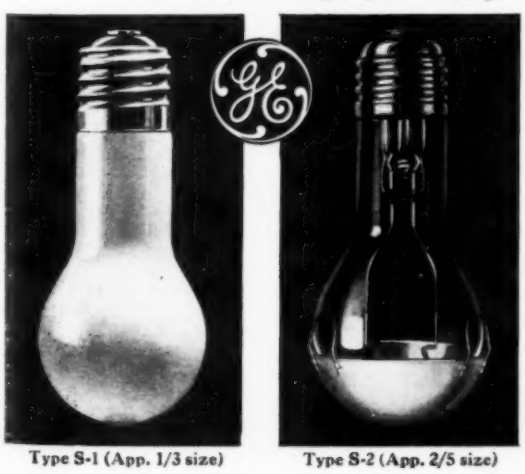

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Accepted by the Council on Physical Therapy of the American Medical Association

Notice these two MAZDA Sunlight Lamps. A pool of mercury in the bulbs of these lamps forms a "mercury vapor arc" rich in ultra-violet. Special filter glass in the bulb cuts out the radiation not found in the best natural sunlight. Goggles are no more necessary with MAZDA Sunlight Lamps than with natural sunlight. The Type S-1 lamp at a distance of thirty inches for a period of ten minutes and the Type S-2 lamp at twenty-four inches for twenty minutes give ultra-violet equivalent of the best *midday midsummer sunlight*. And both give good light for illumination. Mail coupon for book.

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men and women, are or should be interested in hospitals and clinics, as well as in all phases of public health nursing.

In common with all who are carrying on an educational program, the nurse must check on the objectives she herself has set up. Constant reporting to someone else may make her forget that she is the most important person to report to.

This self-checking will keep before her the fact that she is playing a dual rôle, that of educator and nurse. The real educators of the world have always been learners. Keeping in touch with events in the various fields of nursing and the newer movements in education will serve to vitalize the nurse's job and to keep her keen and alert.

The importance of the nurse in any capacity cannot be overestimated, but she becomes doubly valuable in this larger interpretation of her position. As a lay health worker, I have had the opportunity of working with many nurses and have seen the splendid results attained by those whose vision encompassed this ideal.

Survey Finds Separate Contagious Hospitals Not Needed

The New York City visiting committee of the State Charities Aid Association has just published a "Survey of the Communicable Disease Hospital Needs of the Borough of the Bronx."

The committee, requested to consider whether the Bronx needed a contagious hospital and where it should be placed, as a result of its study reached the conclusion that, speaking broadly, "there should be hereafter no separate hospitals established in New York City for communicable diseases; that communicable diseases should be cared for in special and separate buildings in connection with general hospitals."

The report covers the following five major aspects of the problem:

1. The population of the Bronx, its past and expected future growth and its distribution of population, particularly in relation to children under fifteen years of age, the time of life when most acute communicable diseases occur.

2. The incidence of the four acute communicable diseases which comprise most of the hospitalized contagion, namely, diphtheria, scarlet fever, measles and whooping cough.

3. The hospitalization of Bronx patients, and an appraisal of the plant and location of Riverside Hospital in the Bronx, with a view to (a) its adequacy for the care of acute communicable disease as required by modern hospital practice; (b) the suitability of its location from the standpoint of accessibility for the majority of the Bronx families.

4. Visiting nurse care of Bronx patients with acute communicable disease by the Henry Street Visiting Nurse Service.

5. The trend in communicable disease hospital planning and administration, with reference to (a) the advantages of combining such hospital units with general hospitals, contrasted with their construction and operation as independent institutions; (b) the use of communicable disease hospital facilities for other kinds of cases during periods of low prevalance of acute contagion.

The Committee's Recommendations

Combinations of communicable disease and general hospital services have been in successful operation in large cities of New York State and elsewhere in the country for many years, the survey points out. The advantages are shown to be many.

The committee reached the following conclusions relating to general policies as a result of the study:

1. Hospitals for communicable disease should, in the interests of patients and in the interests of economy, be constructed and administered as part of a general hospital and not as a separate institution.

2. Home care of acute communicable disease cases through an efficiently organized visiting nurse service is an effective and economical method of controlling contagion.

The committee made these recommendations:

1. That modern hospital accommodations for the care of patients with acute communicable disease be provided by the city in the Bronx, in the form of a pavilion of a general hospital.

2. That such accommodations be located in the central part of the borough.

3. That if sufficient land is available on the grounds of Fordham Hospital or near to it, the proposed communicable disease unit be constructed and administered as part of that institution.

4. That the initial capacity of such a unit, if the Bronx alone is to be served, be at least 200 beds and not more than 250 beds.

5. That if the Washington Heights section of Manhattan is included with the Bronx in the area to be served, 300 beds should be the maximum initial provision.

6. That the construction should be such that additions to the bed capacity may be economically made if future need for increased accommodations is demonstrated.

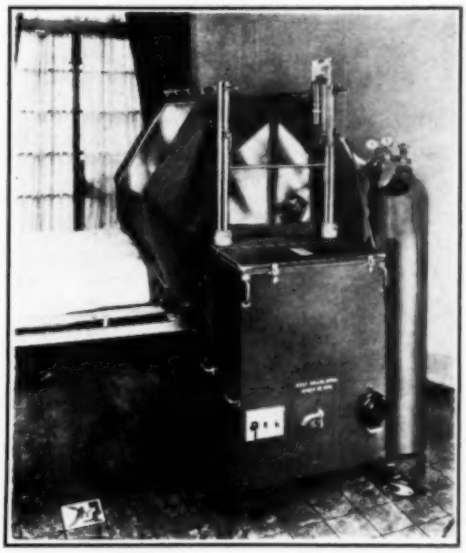
7. That formal provision be made by the city for the bedside nursing care of certain cases of acute communicable disease in the homes of the patients, through organized nursing services.

Is Your Hospital Adequately Prepared For Pneumonia This Winter?

IT IS a self-evident fact that in every hospital where patients are treated for whom oxygen is indicated, there should be at least one oxygen tent. Many hospitals have more, few hospitals have less. The greater the bed capacity, the more tent units there should be.

It is not an over-statement to say that modern, scientific medical treatment *requires* oxygen therapy in the combatting of certain conditions of obvious oxygen want.

What of your own hospital? Are you prepared to treat your patients with oxygen, or must you "send out" for equipment when the attending physicians prescribe oxygen therapy?



We wish to direct your attention to the new Barach-Thurston "Solarium" Oxygen Tent—a tent scientifically designed for the effective administration of oxygen, and for the comfort of the patient. Representing a distinct advance in the field, this tent embodies such desirable features as a vastly enlarged canopy (hood), which can be extended to cover more than half of the bed, a *silent* motor-blower unit, rheostatically controlled and capable of delivering a more-than-adequate circulation of air, and a unique, partitioned ice compartment containing enough ice for 10-12 hours of continuous operation. The above-mentioned features, together with an ingenious by-pass construction, permit exact temperature, oxygen, and humidity control, to a degree hitherto not possible. This is a tent which was designed for but one purpose—the *effective* administration of oxygen therapy—and all the regulations formulated by the medical profession to this end, have been considered and met. It is a tent pre-eminently designed and suited for hospital use, and therefore, not a "one season" piece of apparatus.

We invite competitive examination and test with any other oxygen tent on the market. As we maintain branch offices in many cities of the United States, and have representation in many others, we are prepared, in many cases, to conduct these demonstrations and tests *in your own hospital*, under conditions to be stated by yourselves.

With the purchase of a Barach-Thurston Solarium Oxygen Tent, as with the purchase of any other apparatus manufactured or sold by us, goes a comprehensive guarantee — a guarantee which will mean something to you since it assures you of *near-by* aid and assistance at any time.

We solicit your inquiry. We also stand ready to rent equipment (with full service) at any time, anywhere.

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NEWS OF THE MONTH

Education of Public Is Featured at A. C. of S. Meeting

THE practical application of public relations was efficiently and forcefully demonstrated in St. Louis, from October 17 to 20 when the fifteenth annual hospital standardization conference of the American College of Surgeons was held.

It is estimated that approximately 100,000 citizens of St. Louis were addressed by various authorities attending the meeting and radio talks

Dr. Malcolm T. MacEachern.

each day reached many more listeners. Newspaper publicity was well handled and it was the general consensus of opinion that the citizens of St. Louis and the surrounding country received a great deal of benefit from this educational campaign, staged under the direction of Dr. Malcolm T. MacEachern, associate director, American College of Surgeons.

The speakers chosen by Doctor MacEachern this year included hospital superintendents, editors, pathologists, roentgenologists and well known surgeons. Robert Jolly, superintendent, Memorial Hospital, Houston, Tex., gave approximately thirty-five speeches during the week. Dr. R. C. Buerki, director, Wisconsin General Hospital, Madison, was another hospital administrator who spoke. Dr. J. J. Moore, pathologist, Chicago, well known to hospital people, gave several speeches, as did John A. McNamara, executive editor, THE MODERN HOSPITAL. Every high school student in St. Louis was given the story of hospitals and their relation to the community. Every civic club in the city was addressed on this subject. Many speeches were given in churches, and on Wednesday evening in the gymnasium of St. Louis University a community health meeting was held. To this members of the public were invited and came in large numbers. In addition to those who spoke, much credit is due to Father Alphonse M. Schwitalla, president, Catholic Hospital Association and dean of the St. Louis Medical School, and the hospital administrators of St. Louis.

Approved Hospital List Presented

All those who were addressed by the speakers were urged to visit some hospital and to become thoroughly acquainted with the functioning of the various departments in the hospital. Arrangements were made with the St. Louis hospitals to expect these visitors and to join in this nationwide campaign on public relations which will undoubtedly result in much good will for all institutions.

The standardization conference opened on Monday morning with Dr. Allen B. Kanavel, president, American College of Surgeons, presiding. An address of welcome was given by Dr. Curtis H. Lohr, hospital commissioner, St. Louis. The president elect of the American College of Surgeons, Dr. J. Bentley Squier, responded to the welcome. Next was presented the 1932 list of approved hospitals by Dr. Franklin H. Martin, director general, American College of Surgeons.

Doctor Kanavel spoke on the standardized hos-

NEWS OF THE MONTH (Cont'd)

pital as a medical education center; Dr. G. Harvey Agnew, secretary, department of hospital service, Canadian Medical Association, Toronto, spoke on the changing relationship of the doctor and the hospital; Dr. Daniel Crosby, Oakland, Calif., spoke on medical and hospital economics; Dr. John O. Bower, Temple University, Philadelphia, spoke on reducing the mortality rate from appendicitis; Dr. William Thalhimer, director of laboratories, Michael Reese Hospital, Chicago, discussed oxygen therapy, and a general discussion followed.

Doctor Kanavel also presided on Monday afternoon, and E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, opened the program with a paper on the problems affecting hospital administration. This was discussed by W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg. The second paper was given by Arthur J. Swanson, superintendent, Toronto Western Hospital, in which he told how the economic conditions were being met in Canada. Mary M. Roberts, editor, the *American Journal of Nursing*, talked on the necessity of a common meeting ground for doctor, nurse and hospital administrator. This was discussed by Dr. Donald Guthrie, chief surgeon, Robert Packer Hospital, Sayre, Pa. The closing talk was given by Father Schwitalla on the basic standards for schools of nursing.

Hospital Administration Problems Discussed

Dr. Louis H. Burlingham, superintendent, Barnes Hospital, St. Louis, presided at the Tuesday morning session, which was held in the Tuttle Memorial Auditorium. The first speaker on the program was Dr. B. C. MacLean, superintendent, Touro Infirmary, New Orleans. He spoke on hospital administration in New Orleans from an economic standpoint. This was followed by an interesting symposium which dealt with efficiency and economics as applied to the laboratory, the x-ray department, the physical therapy department, the anesthesia department, the dietary department and the surgical department. A general discussion was opened by E. E. King, superintendent, Missouri Baptist Hospital, St. Louis.

One hundred questions on hospital administration, most of them intensely practical, formed the basis for a round table conducted on Tuesday afternoon by Doctor Buerki.

The standardization conference was held at the evening meeting on Tuesday, at which time Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago, presided. Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., presented an interesting paper on the selection of trustees. This was discussed by Frank Rand, president, board of trustees, Barnes Hospital, St. Louis. Following this Dr. Christopher G. Parnall, medical director, Rochester General Hospital, Rochester, N. Y., stressed the responsibility of the governing body in the selection of a superintendent. The last paper on the program was presented by Mr. McNamara on the removal of the influence of politics from hospitals. His paper was discussed by Dr. E. P. Hogan, Birmingham, Ala.

Demonstrations Held at Two Hospitals

A general discussion was opened by Rev. R. D. S. Putney, superintendent, St. Lukes Hospital, St. Louis, in which he stressed the point that the best way to educate trustees was to have them read the book entitled "What Every Hospital Trustee Should Know." His discussion was followed by remarks from Doctor MacEachern who endorsed the sentiment regarding the removal of politics from hospitals. He stated that one hospital on the West Coast had been left off the list because it allowed osteopaths to practice in it. He said that another county hospital in the Middle West often accused of political activity had been given until January 1, 1933, to carry out sixty-four recommendations. He told of other hospitals which were or would be disciplined by the college unless they absolutely got rid of their political influence.

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, presided at the meeting on Wednesday morning. Many subjects of interest were scheduled for this time, including a discussion on communicable diseases, responsibility for clinical records, social service, the treatment of cancer and other subjects.

Robert Jolly conducted the round table Wednesday afternoon at the Tuttle Memorial Auditorium.

Thursday was given over to conferences and demonstrations conducted by Doctor MacEachern and Mr. Jolly. On Thursday morning a demonstration was held at the Jewish Hospital, and on Thursday afternoon a similar demonstration was held at St. Mary's Hospital.

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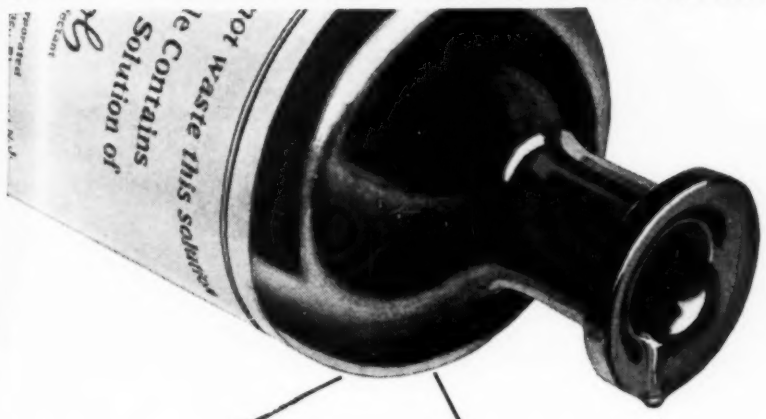

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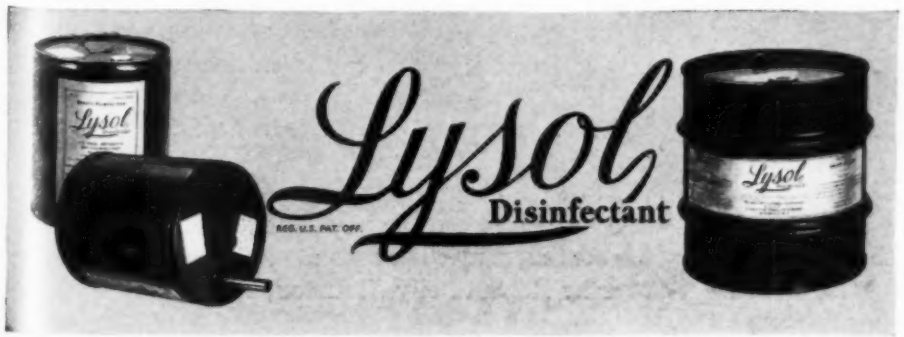

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NEWS OF THE MONTH (Cont'd)

"Press On" Is Keynote of Record Librarians' Meeting

TWO resolutions were adopted at the fourth annual conference of the Association of Record Librarians of North America, held in Detroit, September 12 to 16.

The first resolution provided that each hospital now conducting classes for the training of record librarians shall submit its curriculum to the executive committee of the association for examination and approval and that the curriculum in every case shall include instruction in elementary anatomy. The resolution provided that the same conditions shall also apply in the case of any classes that may be organized in the future.

In the second resolution the association voted not to recognize graduates of record librarian training classes conducted in hospitals of less than 200 beds that are not approved by the American College of Surgeons.

The keynote of the conference was struck by Grace W. Myers, librarian emeritus, Massachusetts General Hospital, Boston, and honorary president of the association, when she reconstructed the word "depression" into the phrase "press on."

Evelyn Vredenburg, Woman's Hospital, New York City, was named president-elect, and Betty Gray, Memphis, Tenn., corresponding secretary.

President's Report Indicates Progress

Maurine S. Wilson, Ravenswood Hospital, Chicago, president of the association, presided at the opening session on Tuesday morning. Among those who spoke were Dr. Bert W. Caldwell, executive secretary, American Hospital Association; Edith Cavanaugh, president, Michigan Chapter of Record Librarians; Grace W. Myers; Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons; Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago, and Dr. Harley A. Haynes, director, University Hospital, Ann Arbor, Mich.

The president's report pointed out that there had been a healthy growth in the organization during the past year.

Jessie Harned, Rochester General Hospital, Rochester, N. Y., presided at the Tuesday afternoon session. Papers were read by Dr. William H. Marshall, internist, Hurley Hospital, Flint, Mich.; Matthew O. Foley, editorial director, *Hospital Management*, and Dorothea M. Trotter, Blodgett Memorial Hospital, Grand Rapids, Mich.

Two Round Tables Are Conducted

The Wednesday morning session was conducted by Alice G. Kirkland, Samuel Merritt Hospital, Oakland, Calif., and papers were read by Marguerite Simmons, medical librarian, Ravenswood Hospital, Chicago, Dorothy Ketcham, director of social service, University Hospital, Ann Arbor, Mich., and Dr. T. R. Ponton, superintendent, University Hospital, Augusta, Ga.

At the Wednesday afternoon session, presided over by Edith Cavanaugh, the following persons read papers: Dr. William J. Butler, urologist, Blodgett Memorial Hospital, Grand Rapids, Mich.; Minnie G. Morse, librarian consultant, Cheyenne, Wyoming; Florence G. Babcock, University Hospital, Ann Arbor, Mich., and Edna K. Huffman, St. Luke's Hospital, Davenport, Iowa.

On Thursday morning John A. McNamara, executive editor, THE MODERN HOSPITAL, told the librarians how they can help the hospital in its public relations program. Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison, Wis., and Dr. Charles W. Moots, hospital representative, American College of Surgeons, each conducted a round table.

Papers were read by the following at the Friday morning session: Esther Badger, Woodland Clinic, Woodland, Calif.; Jessie Morris, Butterworth Hospital, Grand Rapids, Mich., and Grace W. Myers. The discussion was led by Gertrude Edelman, Jewish Hospital, Cincinnati.

Alice G. Kirkland, incoming president, outlined in a brief address the policy of the association for the coming year. The annual banquet was presided over by Robert Jolly, Houston, Tex.

NEWS OF THE MONTH (Cont'd)

Private Hospitals Ask City for Higher Charity Rates

Henry J. Fisher, president, United Hospital Fund of New York, in a recent communication addressed to Mayor McKee, New York City, stated that large expenditures to provide additional general hospital beds in municipal hospitals can be avoided if the city will take advantage of the investments already made in private hospitals.

Mr. Fisher stated in his letter that the privately supported hospitals are equipped and ready to take care of the overflow from the municipal institutions if a financial allowance is made them equal to the cost to the city in providing such care in the public hospitals. He said that such an arrangement would assist the private hospitals to continue their work in caring for the many persons who are not eligible for care in municipal hospitals, but who are able to pay the private hospitals only a small part of the expense incurred in their behalf.

Colorado Hospital Group to Meet

The Colorado Hospital Association will hold its annual meeting at Colorado Springs, Colo., November 10 and 11. The Antlers Hotel will be headquarters for the gathering.

Nursing League Offers Christmas Cards and Calendar

The National League of Nursing Education has announced that it will follow its usual custom of presenting a calendar for distribution around Christmas time.

The title of the 1933 calendar is *Quo Vadis?* It is a hanging calendar, containing quotations from modern educators, philosophers and old writers. The cover page is from a painting by H. Willard Ortlip, who painted the cover page for the Florence Nightingale calendar. The calendar is arranged with two weeks on each page.

In addition to the calendar the league is undertaking a new project this year. It is offering a set of six distinctive Christmas cards on nursing subjects, designed for use by nurses in sending their Christmas greetings. Five of these cards are sketches in black and white and one is in color.

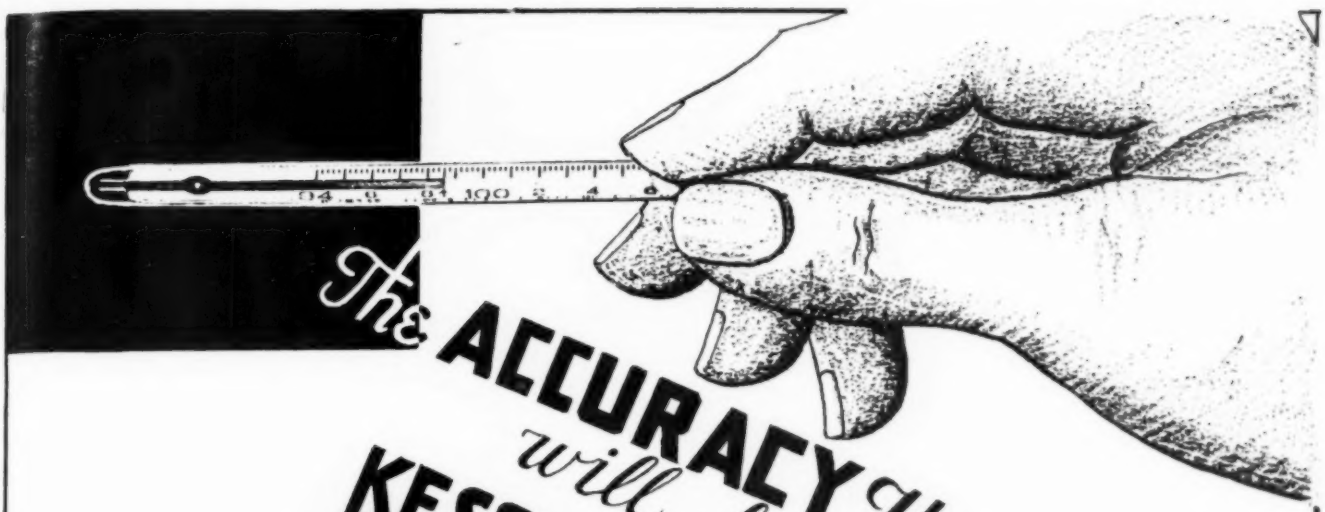
The price of the calendar will be $1. If fifty or more are ordered, the price will be 75 cents a copy.

Individual or assorted cards with matching envelopes may be ordered in lots of six or one dozen. The price for six cards and envelopes is 50 cents (unboxed); in attractive Christmas boxes the cards are priced at $1 a dozen.

National Advertiser's Action Will Aid Hospitals

The widespread movement afoot to foster the interests of hospitals through a public relations program will gain emphasis through the public-spirited action of one of the largest advertisers in standard magazines. As a part of its "health series" of ads this company will place a full-page advertisement, "A Fortress of Health," reproduced here, in the December issue of each one of a large group of national magazines.

"Appreciate Your Local Hospital" is the central

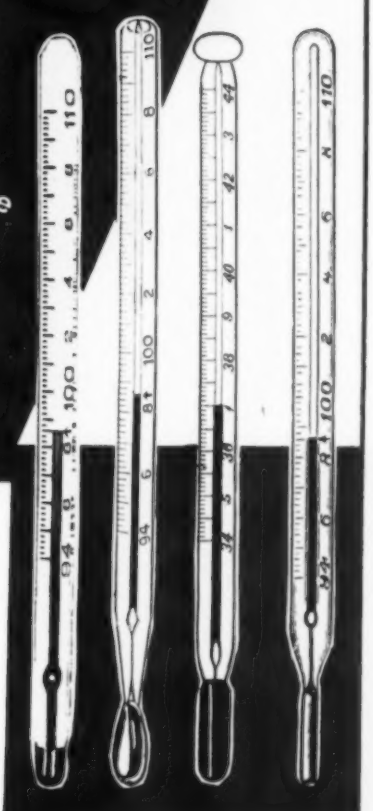


The ACCURACY Hospitals demand will be found in KESSLING THERMOMETERS

The thermometers you use must be accurate, dependable at all times. This 40 year old organization knows how to meet the high standards of hospitals thruout the country.

In Massachusetts, where rigid laws govern the sales of clinical thermometers, over 50% of all thermometers sold were KESSLING THERMOMETERS.

More proof? — send for samples of any or all of the thermometers pictured herewith. They are yours without cost, — and then you can prove to yourself their accuracy — servicability — and test how the markings will stand up when immersed in alcohol or phenol.



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NEWS OF THE MONTH (Cont'd)

theme of the page. The copy in brief and pointed paragraphs gives a picture of what a hospital stands for, what it has to offer, why citizens must constantly resort to it and rely on it and why they should generously sustain it. A charcoal sketch of the Columbia-Presbyterian Medical Center, New York City, appears at the top of the advertisement.

Full Time Secretary for Chicago Association

At the meeting of the Chicago Hospital Association held on October 26 it was proposed that the association hire a full-time secretary whose duties would be to take care of legislative matters, work out a plan of group insurance and generally further the interests of the association.

The proposal met with hearty enthusiasm on the part of those present, and a committee of which J. Dewey Lutes, superintendent, Ravenswood Hospital, is chairman, was appointed to study ways and means for carrying out the proposal.

The attendance at the meeting was the best that the association has so far enjoyed. Charles A. Wordell, superintendent, St. Luke's Hospital, presided, and John C. Dinsmore, superintendent, University of Chicago Clinics, presented a proposed schedule of programs for the monthly meetings for the coming year.

Indigent Relief in Alameda County Unified Under One Head

All indigent relief in Alameda County, California, including in-patient and out-patient care, has been placed under the direction of Dr. B. W. Black, medical director, Highland Hospital, Oakland, Calif. The change was brought about at a recent meeting of the board of supervisors of Alameda County. The County Institutions Commission was given general supervision of relief work.

In the future the county doctors making calls at the homes of indigents will work under the direction of Doctor Black and the County Institutions Commission who have also been given the responsibility of developing a health department to cover the unincorporated territory in Alameda County.

Appeal Made to President Hoover on Veterans' Hospitalization

Opposition of the American Hospital Association to the construction of additional hospitals by the Federal Veterans' Administration was expressed by Dr. J. L. McElroy, special representative of the association, in a recent conference with President Hoover at the White House.

Doctor McElroy called the President's attention to the fact that there now exist an enormous number of vacant beds in private and public hospitals and urged that legislative measures be taken to stop the continuous building of government hospitals in the country. He appealed to the President for the hospitalization of Veterans' Bureau cases in existing hospitals in the localities in which the patients live.

President Hoover expressed his interest in the situation and his willingness to recommend such legislation.

Doctors to Open Low Cost Medical Clinic in Chicago

A new low cost medical and dental clinic for the treatment of all ailments will be opened in Chicago about November 1, according to an article in the *Journal of the American Medical Association.*

The operators of the new clinic will be the United Medical Service, Inc., an Illinois corporation which was formed two years ago by a group of Chicago physicians. This corporation is a subsidiary of a Delaware corporation, set up for profit and in which common and preferred stock will be sold.

"The charters of the corporation," the article says, "indicate that it is proposed to offer complete medical service, including hospitalization, diagnostic care and treatment, and it is proposed to sell drugs and medicines at cut rates made possible by large scale buying. The charters seem to take in enough territory to establish positively the fact that this is a corporation, established for profit, to vend the services of physicians to the public. It is apparently not planned to limit operations to Chicago."

Dr. J. G. Berkowitz, formerly director of the Public Health Institute, Chicago, will head the new clinic as president.

SLOAN EQUIPPED!

A Partial list of recent SLOAN Hospital Installations

DOMESTIC

Westport Sanitorium, Westport, Conn.
Freedmen's Hospital, Washington, D. C.
State Hospital, Kankakee, Ill.
Northern Indiana Hospital, Logansport, Ind.
Springfield State Hospital, Sykesville, Md.
Boston City Hospital, Boston, Mass.
Addison Gilbert Hospital, Gloucester, Mass.
Monson State Hospital, Palmer, Mass.
State Hospital, Ypsilanti, Mich.
Burge Hospital, Springfield, Mo.
Soldiers' Home Infirmary, St. James, Mo.
City Infirmary, St. Louis, Mo.
Hudson Co. Tuberculosis Hospital, Secaucus, N. J.
Greenpoint Hospital, Brooklyn, N. Y.
Kingston Hospital, Brooklyn, N. Y.
Brooklyn State Hospital, Creedmoor, N. Y.
Community Hospital, Glen Cove, N. Y.
Loomis Sanitorium, Loomis, N. Y.
Middletown State Homeopathic Hospital, Middletown, N. Y.
Bellevue Hospital, New York, N. Y.
N. Y. Academy of Medicine, New York, N. Y.
Barton Hepburn Hospital, Ogdensburg, N. Y.
State Hospital, Ray Brook, N. Y.
Monroe County Hospital, Rochester, N. Y.
Harlem Valley State Hospital, Wingdale, N. Y.
Jewish Hospital, Cincinnati, Ohio
Children's Tuberculosis Preventorium, Cincinnati, Ohio
Municipal Hospital, Alva, Okla.
St. Luke's Hospital, Bethlehem, Pa.
Byberry Hospital, Byberry, Pa.
State Hospital for Crippled Children, Elizabethtown, Pa.
Hamot Hospital, Erie, Pa.
Norristown State Hospital, Norristown, Pa.
Wills Eye Hospital, Philadelphia, Pa.
Presbyterian Eye & Ear Hospital, Pittsburgh, Pa.
Farview State Hospital, Wymart, Pa.
Memorial Hospital, Pawtucket, R. I.
Columbia Hospital, Columbia, S. C.
Berkley County Hospital, Moncks Corner, S. C.

RECENT NOTABLE INSTALLATIONS

N. Y. Hospital—Cornell Medical Center
New York

Columbia—Presbyterian Medical Center
New York

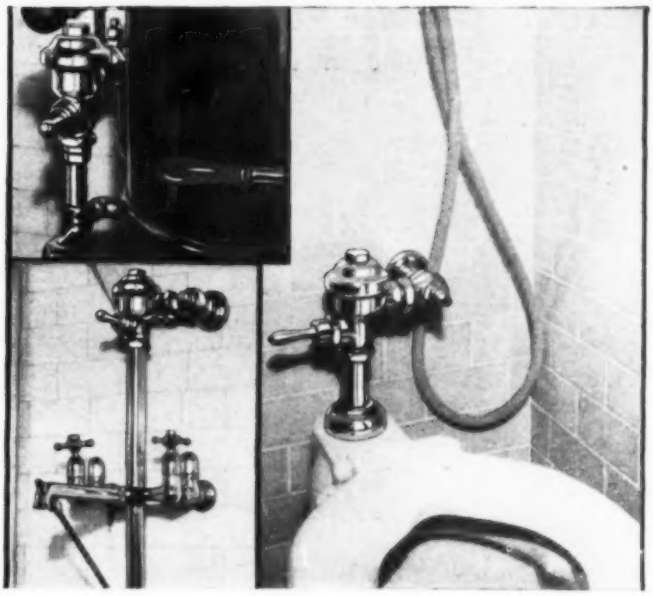
Kings County Hospital
Brooklyn

Lakeside Hospital and Medical Center
Cleveland

Cook County Hospital
Chicago
(Replacing present equipment)

Harborview Hospital
Seattle

Los Angeles County Hospital—Acute Unit
Los Angeles



Austin State Hospital, Austin, Texas
Buxton Hospital, Newport News, Va.
Tuberculosis Sanitorium, Richmond, Va.
State Insane Hospital, Waterbury, Vt.
Stark Hospital, Milwaukee, Wis.
Sheboygan Memorial Hospital, Sheboygan, Wis.
U. S. Veterans' Hospital, St. Petersburg, Fla.
U. S. Veterans' Hospital, Augusta, Ga.
U. S. Veterans' Hospital, Danville, Ill.
U. S. Veterans' Hospital, Hines, Ill.
U. S. Veterans' Hospital, Wichita, Kans.
U. S. Veterans' Hospital, Lexington, Ky.
U. S. Veterans' Hospital, Perrysville, Md.
U. S. Veterans' Hospital, Bedford, Mass.
U. S. Veterans' Hospital, Ft. Snelling, Minn.
U. S. Veterans' Hospital, Lincoln, Nebr.
U. S. Veterans' Hospital, Sunmount, N. Y.
U. S. Veterans' Hospital, Aspinwall, Pa.
U. S. Veterans' Hospital, Johnson City, Tenn.
U. S. Veterans' Hospital, Huntington, W. Va.
Marine Hospital, Seattle, Wash.
Post Hospital, Fort Banks, Winthrop, Mass.
Post Hospital, Fort Bragg, N. C.

CANADIAN

Central Tubercular Hospital, Winnipeg, Man.
St. John Co. Tuberculosis Hospital, St. John, N. B.
Byron Sanatorium, London, Ont.
Ontario Hospital, Penetanguishene, Ont.
Toronto Hospital for Consumptives, Weston, Ont.
Royal Victoria Hospital, Montreal, Quebec
Holy Family Hospital, Prince Albert, Sask.

FOREIGN

Birkenhead General Hospital, Birkenhead, Eng.
Samaritan Hospital, Liverpool, Eng.
Stengard's Hospital, Helsingfors, Finland
Tuberculosis Hospital, Pemar, Finland
Municipal Hospital, Wasa, Finland
Maternity Hospital of Imp. Univ., Kyoto, Japan
Otorhinolaryngology Hospital, Nagasaki, Japan
Nakura Hospital, Tokyo, Japan
St. Luke's Medical Center, Tokyo, Japan
Reitgjerdet Asylum, Trondheim, Norway
Dr. M. Julia Hospital, San Juan, P. R.

SLOAN VALVE CO · CHICAGO

NEWS OF THE MONTH (Cont'd)

Hospital Trustee Honored After Forty Years' Service

George Blumenthal, president of Mt. Sinai Hospital, New York City, was honored on the evening of October 6 at a dinner given by the hospital's board of trustees to commemorate the completion of his forty years' service as director and trustee of the hospital and twenty-one years' service as president.

The speakers of the evening expressed their esteem and affection for their leader and warmly acknowledged the hospital's and the community's indebtedness to Mr. Blumenthal for a lifetime of invaluable public activity.

When Mr. Blumenthal joined the board in 1892,

the hospital was located at Lexington Avenue and Sixty-Seventh Street and boasted a total of 214 beds and a medical staff of fifty-one members. As secretary of the board and subsequently as vice president and president Mr. Blumenthal took a leading part in the development of the institution and helped to bring it to its present preeminent position in the medical world. His understanding of the principles of hospital development and of medical organization on the scientific side, and his courageous approach and generous contributions on the financial side, were largely responsible for the rapid advance of the institution, and helped it through critical periods.

Site Is Acquired for $14,000,000 Medical Center in N. Y. C.

A thirty-five-year accumulation of property near Bellevue Hospital, First Avenue and Twenty-Sixth Street, New York City, as a site for a $14,000,000 medical center for New York University has been completed with the acquisition of extensive property, buildings and equipment formerly owned by the Cornell University Medical College, it was announced recently by Thomas J. Watson, member of the New York University Council and chairman of the council committee in charge of the medical and dental colleges and property.

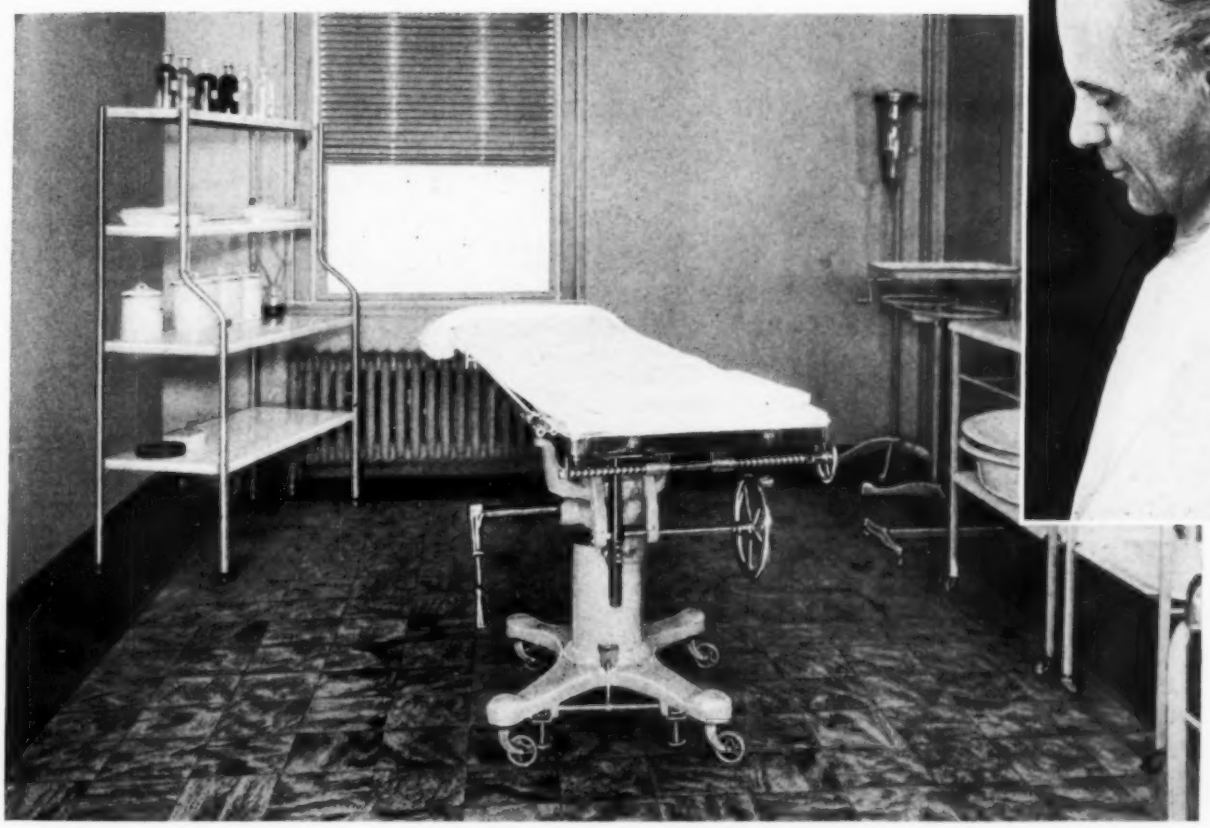
Construction of the medical center will be postponed pending the raising of sufficient funds to carry on the program. Meanwhile the newly acquired buildings will be used by Bellevue Hospital and University Medical College and will become an integral part of the New York University Medical Center in the Bellevue district. The property transfer is said to be the culmination of an extensive health center project.

Illinois-Indiana-Wisconsin Groups to Meet May 3 to 5

The joint meeting of the Illinois, Indiana and Wisconsin Hospital Associations will be held at the Hotel Sherman, Chicago, May 3, 4 and 5, 1933. This will be the fourth year that the three associations have met together.

The presidents of the three associations are: Illinois, J. Dewey Lutes, superintendent, Ravenswood Hospital, Chicago; Indiana, George William Wolf, business manager, Home Hospital, Lafayette; Wisconsin, Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison.

The Surgeon demands a MODERN floor in the operating room



AN AID TO SUCCESSFUL OPERATIONS . . . *the floor in this cystoscopic operating room at the St. Luke's Hospital, Kansas City, Mo., is Armstrong's Linotile.*

"FIRST," the surgeon will tell you, "I want a floor that I *know* is absolutely clean. My reasons for that are obvious to anyone doing hospital work.

"Second, the floor should be resilient and quiet. During delicate operative work I do not want any distracting floor noises. Resilient floors conserve my energy, too—don't tire me out.

"Third—the floor must not be slippery. We can't run the risk of having a nurse, doctor, or patient slipping or falling."

Armstrong Floors fulfill these conditions exactly. They are smooth and resilient, and can be thoroughly cleaned by the simplest methods. That's why so many Armstrong Floors are employed by hospitals in operating rooms, wards, private rooms, corridors, service areas, and recreation rooms.

You should have this book! "Public Floors of Enduring Beauty" gives detailed information about linoleum floors for hospital use. It's free. Address Armstrong Cork Co., 1210 State Street, Lancaster, Pa.

Armstrong's (A) Product

Armstrong's Linoleum Floors

for every hospital need

PLAIN ~ INLAID ~ EMBOSSED ~ JASPÉ — LINOTILE ~ RUBBER TILE ~ CORK TILE ~ ACCOTILE

PERSONALS

LAURA BELLE WILSON has been appointed superintendent, Children's Hospital, Pittsburgh. For the past twelve years she has been principal of the institution's school of nursing and during the past year has also served as acting superintendent of the hospital.

WALTER SCHLARETZKI is the new superintendent, Christian Welfare Hospital, East St. Louis, Ill.

EDNA S. NEWMAN has been appointed temporary dean of the Cook County School of Nursing, Chicago, succeeding LAURA LOGAN, who resigned last June after eight years of service. MISS NEWMAN, who assumed her new duties on October 1, has been assistant dean of the school since 1925.

MARY A. LAMB, formerly connected with the Woman's Hospital, Philadelphia, has been named superintendent, Burlington County Sanatorium for Tuberculosis, New Lisbon, N. J.

SISTER M. GENEROSE, formerly superintendent of St. Francis Hospital, Freeport, Ill., has been transferred to St. Joseph's Hospital, Joliet, Ill., where she will serve in the same capacity. SISTER M. SYLVIA has been appointed her successor at the Freeport institution.

WILLIAM J. RATHJE, who for twenty-seven consecutive years served as president, Englewood Hospital, Chicago, died recently in that city.

DR. L. M. MORALES recently assumed the superintendency, Psychiatric Hospital of Porto Rico, Rio Piedras, Porto Rico.

SISTER HARRIET, formerly of St. Joseph's Hospital, St. Paul, Minn., has been appointed superintendent, St. John's Hospital, Fargo, N. D., succeeding SISTER M. GILBERT, who has gone to Trinity Hospital, Jamestown, N. D. SISTER GILBERT has been head of St. John's Hospital for the past six years.

DR. T. R. PONTON'S resignation as superintendent, University Hospital, Augusta, Ga., has been accepted by the board of trustees. DR. L. P. HOLMES, assistant superintendent, has been given temporary charge of the institution.

SISTER POLYCARP has been named superior of St. Joseph's Hospital, Fort Wayne, Ind., succeeding SISTER M. JOSEPHINE, who has been in charge of the institution for the past six years.

HENRIETTA ANDERSON has been appointed superintendent, General Hospital, East Stroudsburg, Pa., succeeding MARY MURPHY, resigned.

SISTER MARY TERESA is the new superintendent, Mercy Hospital, Jackson, Mich., succeeding SISTER MARY STANISLAUS, who has been transferred to Cincinnati after having been associated with Mercy Hospital for seventeen years. SISTER MARY TERESA was formerly associated with St. Lawrence Hospital, Lansing, Mich.

LUCY A. JOHNSON is the new superintendent, Woodstock Public Hospital, Woodstock, Ill.

THELMA SCHNIEDER recently assumed full management of Bellevue Hospital, Brownwood, Tex. The institution was previously superintended jointly by herself and LOVELLE THOMPSON. MISS THOMPSON has accepted an appointment to the United States Bureau of Medicine and Surgery, Great Lakes, Ill.

SISTER MARY AVITUS, formerly of St. Joseph's Mercy Hospital, Ann Arbor, Mich., is the new Sister Superior, St. Joseph's Mercy Hospital, Waverly, Iowa. SISTER MARY FELICITAS, superintendent of the Waverly institution for the past five years, has been transferred to St. Joseph's Mercy Hospital, Cresco, Iowa.

LIEUT. COL. OSCAR SKINNER, U. S. A. Medical Corps, retired, died recently in Washington, D. C. He was formerly superintendent, Columbia Hospital for Women, Washington, D. C. LIEUTENANT COLONEL SKINNER was eighty-seven years of age at the time of his death.

MABEL GRACE WILSON has accepted the position of superintendent, Butler County Memorial Hospital, Butler, Pa., succeeding C. MABEL CAMPBELL. MISS WILSON was formerly superintendent of nurses, Easton Hospital, Easton, Pa. She assumed her new position on October 1.

NELLIE HOFFECKER has been appointed superintendent, Grandview Hospital, Sellersville, Pa., taking over the direction of the institution from MARY SCANLIN, who has been acting in that capacity since the resignation recently of AUGUSTINA ATKINSON, superintendent of the institution. MISS HOFFECKER was formerly connected with Temple University Hospital, Philadelphia.

PERSONALS

DR. PAUL WAKEFIELD, chief of state tuberculosis clinics, Boston, assumed the superintendency, Central Maine Sanatorium, Fairfield, Me. on November 1. Several years ago DOCTOR WAKEFIELD was in charge of the Wuchang General Hospital, Wuchang, China.

THOMAS F. DAWKINS has been named superintendent, Williamsport Hospital, Williamsport, Pa., to succeed the late P. W. BEHRENS.

DR. KENNETH J. TILLOTSON, formerly superintendent, McLean Hospital, Waverley, Mass., has been appointed psychiatrist-in-chief, Massachusetts General Hospital, Boston. He will also serve in the same capacity at McLean Hospital. DOCTOR TILLOTSON will continue his work in the department of psychiatry at Harvard Medical School. DR. W. FRANKLIN WOOD, formerly assistant director, Massachusetts General Hospital, has been appointed director, McLean Hospital.

HALLIE STALEY, formerly superintendent, Elmhurst Hospital, Elmhurst, Ill., is now superintendent, Marietta Phelps Hospital, Macomb, Ill.

MATTIE HENRICKS was recently appointed superintendent, Lutheran Sanatorium and Hospital, Hot Springs, S. D. She will also have charge of the business department of the hospital. MISS HENRICKS was formerly associated with Good Samaritan Hospital, Aberdeen, S. D. She succeeds ERNA MEIER, who has been acting superintendent of Lutheran Hospital and Sanatorium for some time, and who will continue at the institution.

DORATHA LUSCOMB is now superintendent, Houston Eye, Ear and Throat Hospital, Houston, Tex.

DR. W. H. VORBEAU, superintendent, Lima State Hospital for the Insane, Lima, Ohio, died recently of heart disease. He had been ill for several weeks. DOCTOR VORBEAU had been head of the institution for the last eight years.

DR. BYRON M. HARMON was officially reinstated on September 14 in his post as superintendent, Essex Mountain Sanatorium, Verona, N. J.

SISTER M. REGINA has been appointed superintendent, Mercy Hospital, Wilkes-Barre, Pa., succeeding the late SISTER M. BERNARD.

SISTER SIENNA, formerly in charge of Mobile City Hospital, Mobile, Ala., has been transferred to St. Thomas Hospital, Nashville, Tenn., where she will serve as superintendent.

ELIZABETH I. HANSEN was recently appointed superintendent, Harrington Memorial Hospital, Southbridge, Mass. A graduate of Massachusetts General Hospital, Boston, she has served as superintendent, Deaconess Hospital, Buffalo, N. Y., and in the same capacity at Clinton Hospital, Clinton, Mass.

ETHEL KIRCHOFER recently became superintendent, Berger Hospital, Circleville, Ohio. For the past two years she has been operating room supervisor at the institution.

SISTER M. MODESTE, for the last three years assistant superintendent, St. Francis Hospital, Poughkeepsie, N. Y., has been appointed superintendent of the institution, succeeding SISTER M. CYRIL, who held the position the last three years. SISTER CYRIL will remain at the institution as assistant superintendent.

WILLAM S. SINDEY, superintendent, Bronx Hospital, New York City, for the past eight years, recently resigned his position.

DR. ALBERT ANDERSON, superintendent, State Hospital, Raleigh, N. C., died October 16, in his seventy-third year. He had been superintendent of State Hospital for nineteen years.

Hospital Advisory Service Offered by New Organization

Hospital Advisers, Inc., is the name of a new organization that has been formed to offer an advisory service to hospital superintendents and trustees. Offices have been opened at 104 South Michigan Avenue, Chicago.

The board of directors is composed of Ada Belle McCleery, superintendent, Evanston Hospital, Evanston, Ill.; Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago; Alfred C. Meyer, president, board of trustees, Michael Reese Hospital, Chicago, and trustee, Provident Hospital, Chicago; Carl A. Erikson, Schmidt, Garden and Erikson, architects, Chicago.

Patients

Allergic to Wheat, Milk or Eggs

Enjoy these Tempting Whole Rye Wafers

THOSE who direct diets for patients allergic to wheat, milk or eggs need no introduction to the difficulties involved. To include a safe, palatable bread presents a problem nearly as great as that of providing interesting variety in daily menus.

For that reason you will appreciate the safety, palatability and versatility of Ry-Krisp Whole Rye Wafers. Made simply of flaked whole rye, water and a dash of salt double-baked to a tempting crispness—these wafers have a rich rye flavor that is popular with children and adults. They may be eaten with safety at every meal—with as wide a variety of foods as the diets permit.

To assist patients in planning interestingly varied menus—a booklet has been prepared by a reputable dietitian with the co-operation of physicians interested in allergy. To make the booklet practical for the patient's own use, all information is presented simply and concisely. Separate sections are allotted to wheat, eggs and milk—in each the foods permitted and the foods to be avoided are listed. Sample menus and recipes are also included.

We will gladly send you a copy of this booklet, and a package of Ry-Krisp Whole Rye Wafers for testing. Additional copies for distribution among your patients are available upon request. Fill out the coupon and mail it to us.

Ry-Krisp
Whole Rye Wafers

RALSTON PURINA CO., 530 Checkerboard Square, Saint Louis, Missouri

Without obligation, please send me your new Allergy Recipe Booklet, and a sample of Ry-Krisp for testing.

Name.....

Address.....

City.....

This offer limited to residents of the United States and Canada.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

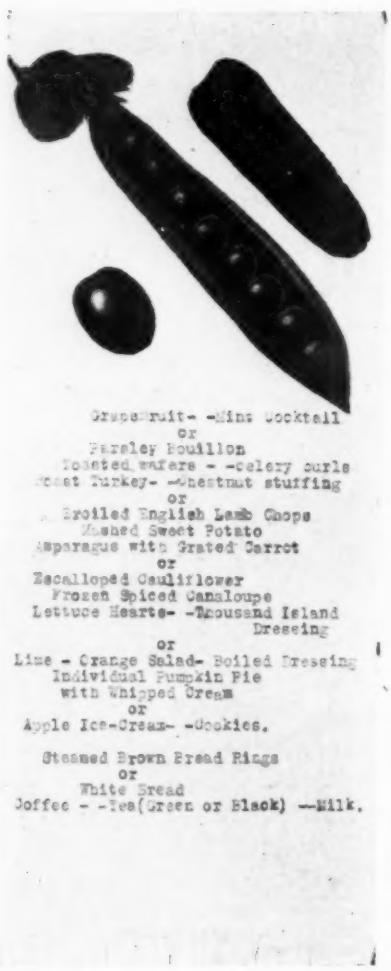
Novel Decorations Add Zest to the Thanksgiving Appetite

By BERNICE McFARLAND
Dietitian, Seaside Hospital, Long Beach, Calif.

ON THAT first Thanksgiving Day years ago there was a celebration. For days ahead of the time the men must have hunted and fished bringing in supplies of turkey, geese, duck, deer, clams and mussels. Over the glowing wood coals in the huge fireplaces the women must have cooked and baked the food—wild turkey with beechnut stuffing, rare venison steaks, great bowls of clam chowder, oysters, the gift of the Indians, barley loaves, cornmeal cakes and baskets overflowing with wild grapes, plums and nuts.

At Seaside Hospital, Long Beach, Calif., we try to keep the traditional Thanksgiving picture before the eyes of our guests and our hospital employees by planning a special menu and tray decoration and creating a holiday atmosphere in the dining rooms.

Since we offer a choice of food, our guests are given a menu for marking on Wednesday morning, when they get the first glimpse of what is about to take place on Thanksgiving. The menu sheet, which is reproduced here, is made from a strip of heavy crêpe paper, light green in color, cut ten by four inches. The top and lower edges are pulled slightly to give the sheet an uneven appearance. Toward the top of the sheet are pasted pictures of fruits, vegetables and autumn flowers which have been cut from labels on canned goods, from seed journals and from advertisements. These pictures are in soft yellow, gold, the deeper tone of the pumpkin and the orange and greens darker than the background of the menu sheet. Below the pictures is typed the menu. On the tray the menu sheet lies flat, and is clipped to the tray cloth where it can be seen easily in serving.



This dainty menu, with its realistic pictures of a shiny purple olive, a golden ear of corn and a dark green pea pod, in relief against pale green crêpe paper, is bound to call forth an appreciative exclamation even from a weary invalid.

Since color is such an important factor in making the tray look attractive as well as in tempting the appetite, a definite color scheme—yellow and green—was chosen. In varying shades this is carried out both in the decorations and on the menus.

A real chrysanthemum nut cup is the only tray decoration. It is made by cutting the stem of a medium sized yellow chrysanthemum close to the flower, so that it will lie flat. This is placed on a lace doily, a little larger than the flower. A few of the center petals are removed from the chrysanthemum, and half of the shell of a large English walnut is inserted.

Quantity Production brings down the Cost of

THIS PRACTICAL COMBINATION BOWL *by Gorham*

WITH COVER 014748

BOWL ONLY 014747

WITH COLLAR 014747
for "supreme" liner

WITH COLLAR 014749
for Delmonico glass

HERE'S a new Gorham combination bowl, 5⅜" in diameter—simpler in line—less expensive (due to quantity production).

The design is Early American in feeling; but this is the kind of a bowl that would be useful with your service.

With its cover, it can be used for soups and cereals . . . without the cover, it is an ideal holder for grapefruit, melon or other halved fruits . . . with its collar for Delmonico glass, for serving orange juice, tomato juice or clam juice . . . with collar to hold "supreme" liner, for fruit or seafood cocktails, bouillon, ice cream.

• • •

The construction is Gorham quality nickel silver base (not less than 18 per cent) heavily silver plated. *No soft metal or soft solder is used in the construction of Gorham hospital ware.* Write for new catalogue just issued.

THE GORHAM COMPANY *Hospital Division*

New York . . . 6 West 48th Street • *Chicago* . . . 10 South Wabash Avenue • *San Francisco* . . . 972 Mission Street •

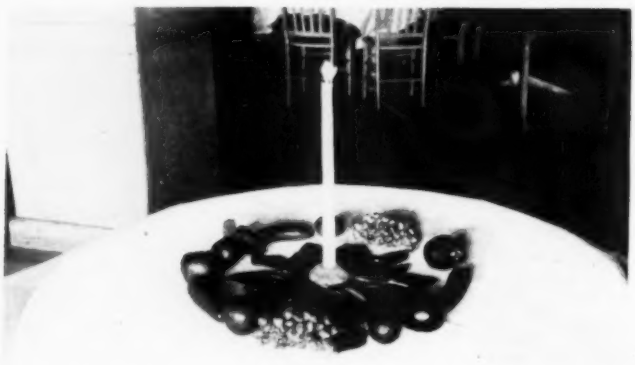
Memorial Tablets and Endowment Plates in Brass and Bronze, write our Bronze Department Q for suggestions and estimates

The walnut shell is filled with candy corn, which makes a pleasing contrast.

Our menu is as follows:

Grapefruit-Mint Cocktail
or
Parsley Bouillon
Toasted Wafers Celery Curls
Roast Turkey Chestnut Stuffing
or
Broiled English Lamb Chops
Mashed Sweet Potato
Asparagus With Grated Carrot
or
Escalloped Cauliflower
Frozen Spiced Cantaloupe
Lettuce Hearts Thousand Island Dressing
or
Lime Orange Salad Boiled Dressing
Steamed Brown Bread Rings or White Bread
Individual Pumpkin Pie With Whipped Cream
or
Apple Ice Cream Cookies
Coffee Tea Milk

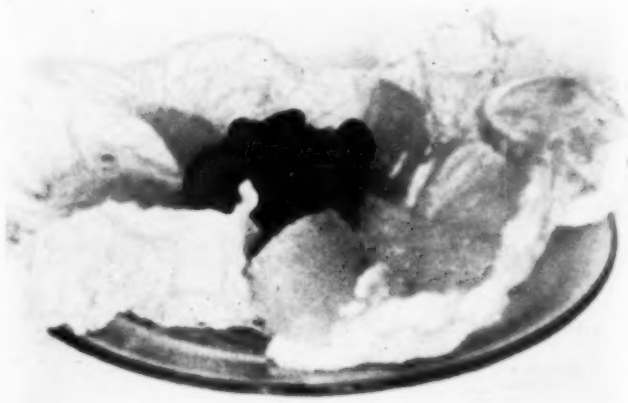
Small cream peppermints crushed and added to the grapefruit give a refreshing and appetizing flavor to the cocktail. This is garnished with a tiny orangette. Unopened cans of spiced cantaloupe, packed in ice and salt for about four hours before serving, offer an easy way to prepare frozen spiced cantaloupe. The salad is made by arranging on a bed of lettuce five or six sections of orange, to resemble petals of a flower. The center of the flower consists of lime gelatine flakes which have



A dining table gay with a bright hued tarlatan cover and a centerpiece formed of grapes, persimmons, tangerines and other fruits and a circle of autumn leaves.

been formed by forcing the gelatine through a potato ricer. Raisins that have been soaked in orange juice are sprinkled over the gelatine flakes. The salad dressing is placed at the side in a tiny paper cup. The apple ice cream is made by adding apple sauce, lemon juice and a dash of cinnamon to any standard ice cream recipe. It is garnished with a green cherry. To make the brown bread rings, cold steamed brown bread is cut into rings with a doughnut cutter, and spread evenly with butter which has been creamed, then the rings are placed together.

The size of the servings of food is important both from the standpoint of the satisfaction of the guest and the waste involved. Since we do not have central service this problem is solved by the



Color appeal is an important part of this tempting salad of orange sections lying on a delicate green lettuce leaf.

making up of sample plates. For instance, a sample of the Thanksgiving salad is made and given to the salad girl, thus enabling her without any loss of time to see exactly the quantity of salad materials required, the amount of dressing and the arrangement of the garnish. A dinner plate showing the best arrangement of the food as it is to go on the tray is sent to each serving kitchen, to illustrate to those who dish the food every detail of the plate.

The menu was planned with a definite relation to the equipment and the help available for its preparation. Since in all departments of the hospital the practice of economy has become necessary, this is a vital consideration. As much of the preparation as possible is to be done before Thanksgiving Day. With the exception of the flowers, all of the decorations for the trays and the dining rooms, salad dressings and cookies are to be completed two days ahead of time. The bouillon, gelatine of the salad, crust for the pie, the ice cream and steamed brown bread will be prepared the day before. When the chef leaves Wednesday evening the turkey and the chops will be ready for cooking at the required time the next day. Of course, all of the vegetables could be prepared for cooking the day before, one of them will be, but there will be plenty of time to prepare the rest of them Thanksgiving morning. With this foresight, all of the last minute worry of the dinner will be eliminated as there will be ample time for everything.

Then comes the question of cost. With the lowered food prices, this may not seem such a difficult problem but at the same time in this uncertain

WHY NOT GIVE YOUR PATIENTS THE *finest pineapple?*

Pineapple Tapioca

(For the high caloric diet). Cook tapioca in boiling salted water, in top of double boiler, until transparent. Cool. Drain Libby's Crushed Pineapple, and add to tapioca. Serve with cream.

YOU CAN DO JUST THAT... ECONOMICALLY ...WITH LIBBY'S

Pineapple Gelatin Salad

(For full diet and staff). Drain Libby's Crushed Pineapple. Dissolve raspberry or cherry flavored gelatin in pineapple juice. Cool. Add pineapple. Pour into molds, and chill until set. Serve on lettuce, garnished with mayonnaise.

Broiled Pineapple

(For private patients). Drain Libby's Sliced Pineapple. Broil. Serve with broiled bacon and buttered peas. Garnish with parsley.

NATURALLY, these days, you're keeping a mighty close check on your budget. Every single cent you spend has to buy better value than ever!

That's why so many dietitians use Libby's Pineapple. Consistently the highest quality—and inexpensive.

You will find that out when you prepare these dishes, with Libby's Pineapple. Attractive, flavorful dishes that patients themselves would choose, and the kind you can serve at low cost.

They'll be richer in flavor, finer in color and texture. For Libby's Pineapple is superb, sun-ripened fruit only. The pick of the Hawaiian crop—in a rich, tangy syrup of natural juice and pure cane sugar.

Because it is so scrupulously selected, and packed within a few hours after picking—by canning experts—Libby's Pineapple never varies in its matchless quality or full-measure pack.

To take advantage of today's low prices, order Libby's Crushed Pineapple, without delay. And make it a point to try Libby's Sliced Pineapple, which gives you *just the center slices!*

Libby, McNeill & Libby
Dept. N-39, Welfare Bldg., Chicago

Libby's 100 Foods

These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries	Pork and Beans	Peas	Boneless Chicken
Tomato Purée	Tomato Juice	Catchup	Stringless Beans
Corn, Beets	Olives, Pickles	Chili Sauce	Santa Clara Prunes in Syrup
Hawaiian Pineapple	Mustard	Salmon	Strawberries
California Fruits	Bouillon Cubes	Evaporated Milk	Loganberries
Spinach, Kraut	Beef Extract	Mince Meat	California Asparagus
Jams, Jellies			

period it is necessary to make the dollar go just as far as possible. As it does not seem possible to estimate accurately the cost of the Thanksgiving dinner alone, the day is taken as a unit and divided by the three meals in arriving at the following figures. Our equipment is electrical, except that gas is used for the coffee urns and steam tables, and there is one gas stove in the diet laboratory. The per capita cost of the Thanksgiving Day meal is estimated as follows: food costs, $0.14; labor, $0.042; electricity and gas, $0.01; menu sheet, $0.003; chrysanthemum, $0.06; candles for dining room, $0.05. The tarlatan cost $0.15 a yard.

In the dining rooms, fruit, vegetables, autumn flowers and leaves are used for decoration. At each end of the steam table are pumpkins hollowed out and filled with autumn flowers. The dining room tables are gay in tarlatan covers of various autumn colors of gold, green, lavender, yellow, brown and rose over the white tablecloths.

The table centerpiece is made by arranging leaves flat on the table in a circle about five inches in diameter. In the center of this is set a candle in a vegetable holder. By the use of an apple corer, potatoes, small squash, carrots and other vegetables may be hollowed out to hold a candle. The outer edge of the centerpiece is formed by arranging grapes, persimmons, tangerines, pears, carrots and other fruits and vegetables following the circle of leaves. By dipping the fruits and vegetables in salad oil, they can be polished with a soft cloth until they have a lovely waxy appearance. The tarlatan covers and candles are used in contrasting colors, for instance, yellow and lavender.

Although most people associate Thanksgiving Day with home and a reunion of relatives and friends, we feel that our extra hospital preparation and work for this day will make happier and more contented guests and employees.

How Bequests for Hospitals May Be Safeguarded

That the Revenue Act of 1932, recently enacted by Congress imposes no federal inheritance tax on hospitals that receive bequests, as some hospital officials have thought, is pointed out in the *Journal of the American Medical Association.*

The purpose of Section 807 of the new act is not to impose an inheritance tax on hospitals, but to limit the deduction for charitable bequests under the estate tax law to such amounts as the testator has in fact or in law devised or bequeathed to charity.

Under the old act, it is pointed out, absurd results were reached. For example, if a testator gave his residuary estate to charity and directed that federal and state death duties be paid out of such residuary estate, the result might be that nothing was left for charity. In such cases, regardless of the fact that charity received absolutely nothing, the old law allowed a charitable deduction from the gross estate of a wholly fictitious sum, namely, what the testator would have given to charity if the federal and state death duties had not absorbed the whole of the residuary estate.

Charitable bequests to hospitals may be safeguarded, the article explains, if the testator makes provision for such bequests before inserting a residuary clause in his will, or if he provides in his will a special fund for the payment of federal and state death duties.

Exposed Pipes Increase Cleaning Costs

In some new hospitals, the much heralded idea of deliberate exposure of plumbing to make it readily accessible seems to have been overdone, according to the report of the committee on hospital planning and equipment of the American Hospital Association.

It is perhaps of advantage to the field that attention has been called to the necessity of having pipes accessible, but it seems to be going too far deliberately to make an ugly dirt pocket behind a kitchen sink by setting it four inches out from the wall, leaving exposed pipes to catch an accumulation of grease and dirt.

Some have contended that hospital planners have sometimes been extravagant in putting so many pieces of equipment on sanitary bases. There seems a tendency for this thought to be carried to unwise extremes. In some very costly buildings, refrigerators, for instance have not been built-in, but are left to stand as semimovable furniture with the worst kind of dirt pockets behind and beneath them. An estimate of the added cleaning costs occasioned by this practice compared to the cost of tiled base and some furring should settle this point when the question is being discussed by the building committee.

The report further points out that while the prevailing tendency to relieve hospital buildings a little from their unfriendly tiled bathroom atmosphere is a laudable one, still the architect is permitted to presume too much if he omits rounded wall corners and fails to provide coved bases in rooms and wards.

HOSPITAL EQUIPMENT AND OPERATION

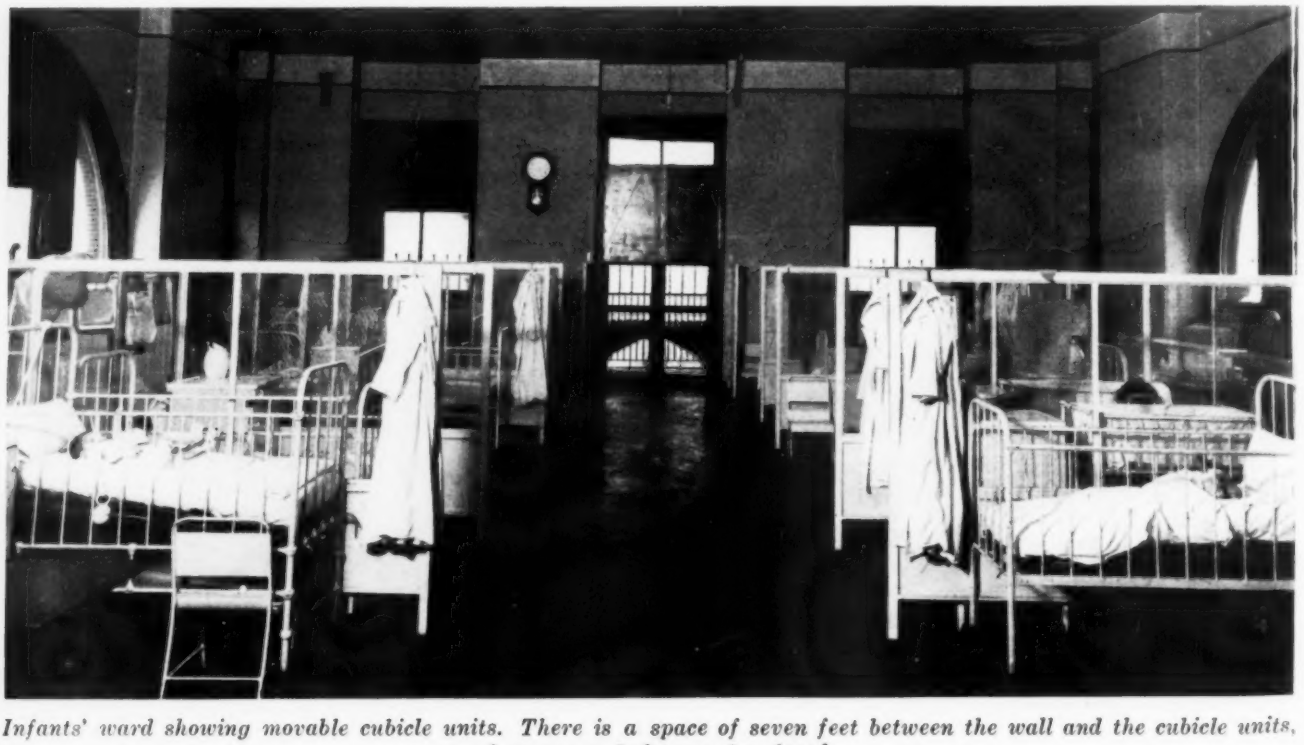
Conducted by C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

Why a Cubicle Unit Is Better Than an Open Ward for Children

By CHARLES HENDEE SMITH, M.D.
Director, Children's Medical Service, Bellevue Hospital, New York City, and
GEORGE VICTOR HARVEY
McKim, Mead and White, Architects, New York City

THE desirability of having cubicles in a children's hospital is generally accepted, for such an arrangement has two main advantages over the open ward plan. First, the separation of children by glass partitions lessens the chances of infection being transmitted from one to another. In the open ward contagion may be spread by cough spray, by passing toys, food and so forth from bed to bed and by the hands of the attendant. The cubicle obviates the danger of the first two almost perfectly and the modern cubicle technique prevents the last. If the nurse puts on a clean gown and washes her hands before going from one patient to another, she is unlikely to carry infection.

The second point of value in the cubicle system is the prevention of drafts. In a private home the



Infants' ward showing movable cubicle units. There is a space of seven feet between the wall and the cubicle units, where extra beds may be placed.

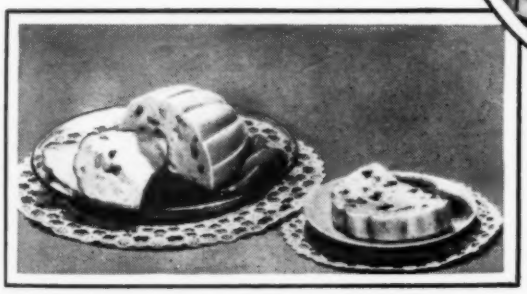
More Jell-O Desserts

and all so economical at the NEW LOW PRICE

JELL-O is a versatile dessert. And now, at its new low price, there are more reasons than ever before for having at least one Jell-O dish on your menus every day. The variations shown below indicate a few possibilities. Tested quantity recipes for new, attractive, delicious, and economical Jell-O desserts are always available.

1. PLAIN MOLDED JELL-O — Even with the simplest service there is a wide variety of possibilities. You can use any one of the six pure fruit flavors, or any two or more of them in combination—for flavor and color appeal. Jell-O may be molded in glasses, individual molds, or large pans; and served solid, cubed, riced or chopped; garnished or plain.

2. FRUIT JELL-O COMBINATIONS—The next step in Jell-O service variations is to add fruits—fresh, cooked, or canned. This is a particularly economical way to use up fruit left over from other uses. Also use nuts, marshmallows, etc., and top off with whipped cream, or leave plain, as desired.



4. BAVARIAN CREAM—In Bavarian Creams, and other richer fruit and nut mixtures, Jell-O contributes flavor, color, and smoother texture. These desserts are also more economical when Jell-O is used, as less of the more expensive ingredients are required, and greater volume is secured.

3. JELL-O SHERBETS—Sherbets made with Jell-O are richer, smoother, and more economical. Jell-O builds up and intensifies the flavor and the color of the fresh fruit. And it cuts the cost, because less fruit juice is needed, and expansion in freezing produces increased volume.

5. FLUFFY LEMON PIE — A new lemon pie called Fluffy Lemon Pie is delightfully different and delicious. This Jell-O pie has a delicate texture, and flavor of the pure fruit. It is a popular addition to the dessert list, and especially the pie list. And, like all Jell-O desserts, it is economical to produce.

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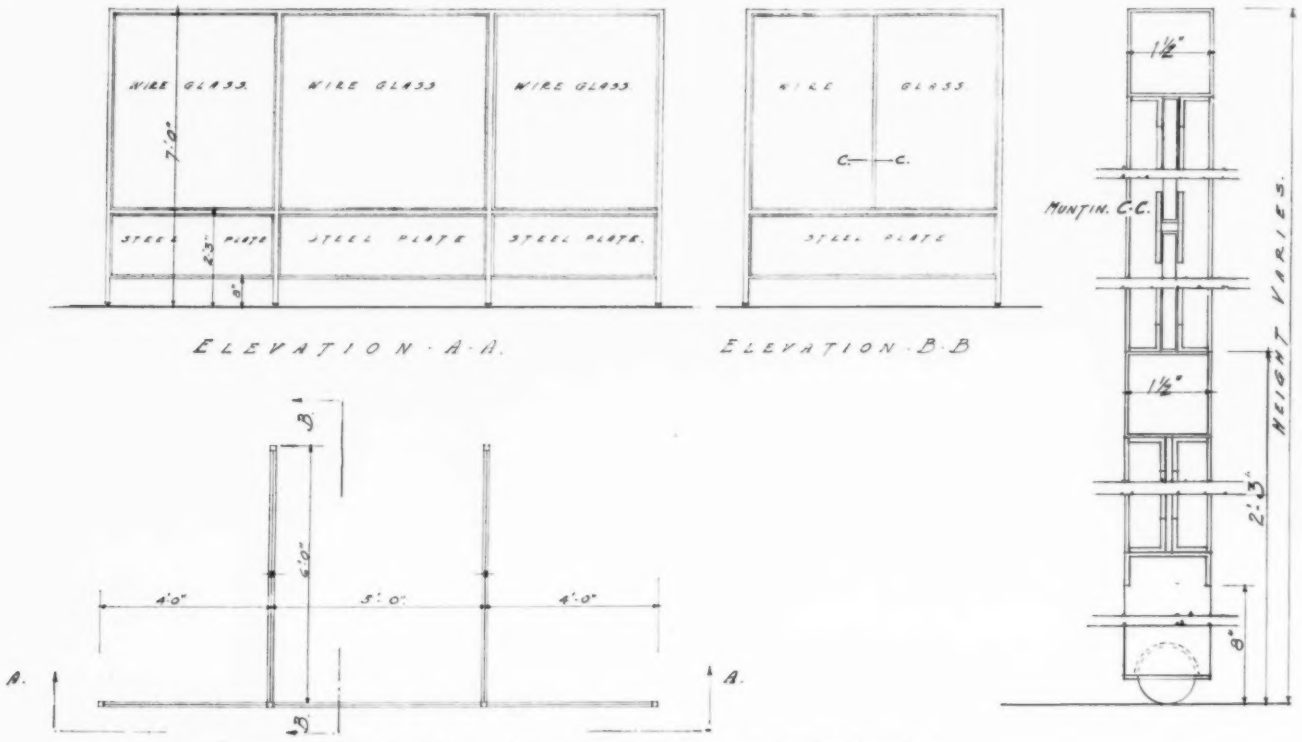
MH 11-32

infant's bed is in the corner of the room away from the window, carefully protected from drafts by a screen or pad covering the side of the crib. In the open ward the baby's crib is usually placed with the head toward the window, under which is a radiator, and with little or no screening of the sides or top of the bed. When the window is open a cold draft strikes the infant's head, when it is closed the heat from the radiator is a bad feature. It is not surprising that respiratory infections are rife in infants' wards. The birthright of the baby is to

straight lines from bed to bed across the ward.

The second plan places all the beds away from the windows, but it has been found in several hospitals that it increases the difficulty of nursing. If a nurse is in a cubicle on one side of the central partition and a child needs quick attention on the other side she must make four right angle turns to reach him.

A fixed cubicle is undesirable because no matter how much thought is given to any plan before a hospital is finished, it is a common experience to



The cubicle unit construction is shown in this drawing.

be kept warm and protected from infections. The open ward fails in both of these essentials.

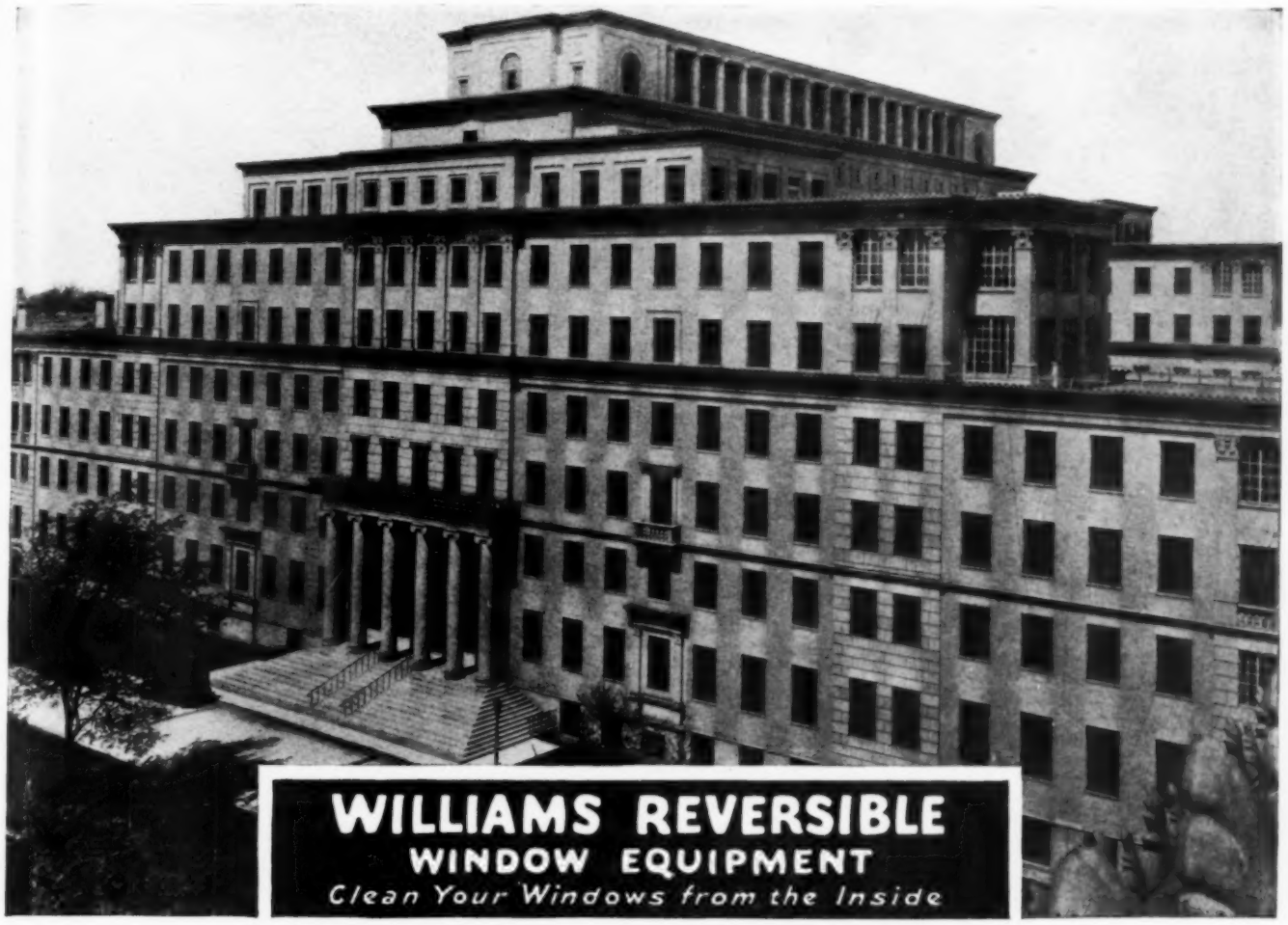
When we come to the arrangement of cubicles in a ward we find two plans in common use. In one the cubicles are stalls around the side of the ward, opening toward the center. In the other they are arranged along a central partition and open outward toward the walls. In planning the cubicle arrangement of the new wards for the Children's Medical Service, Bellevue Hospital, New York City, both of these arrangements were studied and it was evident that both had disadvantages.

The first plan places the heads of the beds toward the windows and radiators, unless only the spaces between windows are used, which means that the capacity of the ward is seriously cut down. A cubicle in front of a window is in a bad position since the bed is even nearer the window and radiator than when it is in the open ward. The advantage of this plan, however, is that it provides easy access to all the patients and the nurse travels in

find that changes are necessary when it comes into use. Although the movable cubicles are heavy, yet four men can move them easily.

The desirable features of a cubicle system are adequate separation, reasonable size, protection from drafts, easy accessibility, complete visibility and elasticity of arrangement. The movable cubicle unit was designed in an effort to fulfill all these requirements. It is merely a longitudinal member, 13 feet long, from which project two perpendicular partitions, making one center cubicle 5 feet by 6 feet, and two end ones 4 feet by 6 feet. It would be somewhat better if the center one were 6 feet by 6 feet and the end ones 4 feet 6 inches or 5 feet by 6 feet. The size of the Bellevue units was determined by the size of the wards.

The cubicle construction is shown in the accompanying illustrations. The uprights are of 1½-inch seamless square tubing, resting on casters designed to roll easily. All cross members are of the same sections as the uprights.



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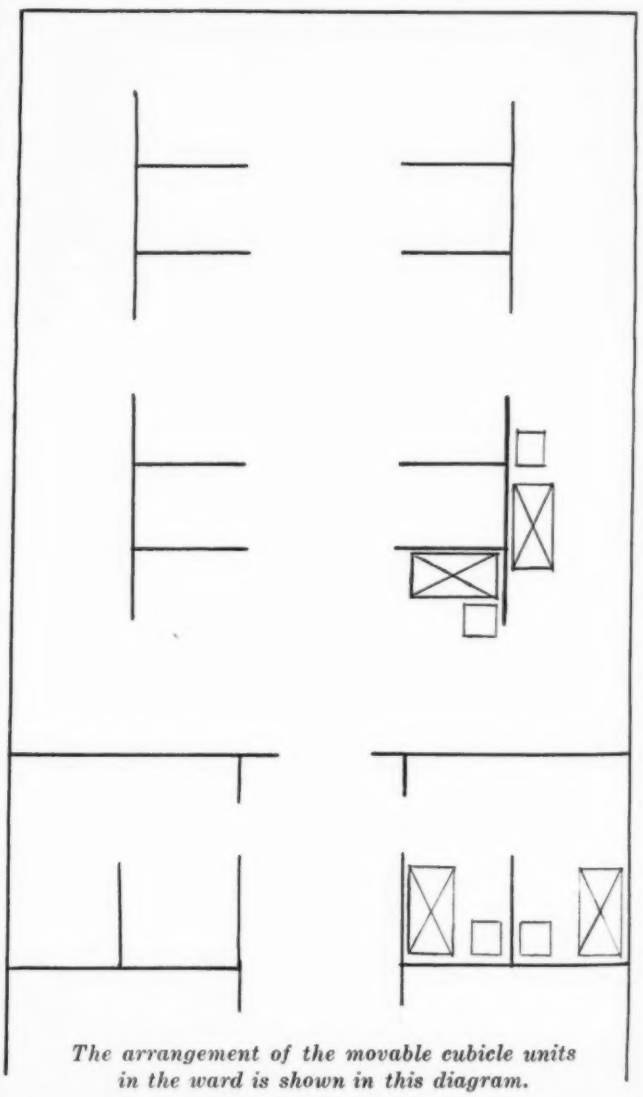
Where glazing occurs a square member is carried through at the bottom, with angles screwed to the posts and cross members to receive it.

Muntins are flat bars ⅛ inch by 1 inch, secured with machine screws between.

The glass is ¼ inch thick polished wire glass, which is necessary since occasionally children will break the glass and need protection from possible splintering. To ensure visibility the bottom of the glass should be no higher than the lowest point at which the mattress can be placed.

The infants' units are only 5 feet high, those for children are 7 feet (6 feet 6 inches would probably be enough). They afford adequate room for a bed and bedside stand. The bed is on large wheel casters and can be moved out into the ward easily for examining or treating the patient. On each cubicle are hooks for gowns and chart holders, the chart thus being left out of the patient's reach.

The units were designed to be movable so that



The arrangement of the movable cubicle units in the ward is shown in this diagram.

they could be arranged differently in the wards. We have tried several different positions and find the best arrangement is to have the cubicles opening toward the center of the ward. This enables the nurse to go from bed to bed in a straight line. The back of the cubicle is toward the window, thus stopping all drafts. It has been found that the air is remarkably still in the cubicles, even though a strong wind is blowing down the center of the ward. The distance from the side walls and windows can be varied. The cubicles can be moved toward the center of the ward, and extra beds can be placed behind them lengthwise along the longitudinal member. Each cubicle unit thus efficiently separates four children. The beds behind the cubicles are used only when the wards are overcrowded. Sixteen children can be placed in a twelve-bed ward. Only the convalescents are put behind the cubicles. Even here there is a considerable degree of protection from drafts, although the ventilation should come from the end windows, not from those near the patients.

Patients are not admitted directly to the wards but to a series of small rooms in which they are kept usually for several days, until the likelihood of contagious disease developing is past. The rooms hold two or three beds separated by partitions of the same type as those in the cubicle unit. This is an efficient method of keeping infections out of the wards.

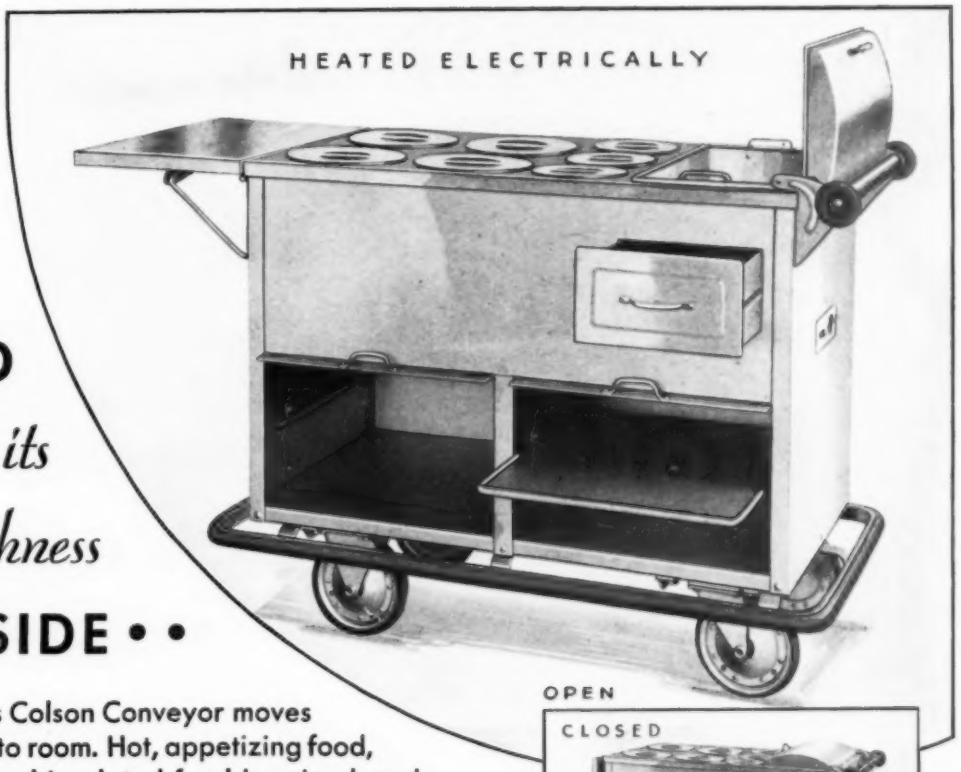
The cubicles at Bellevue Hospital have been in use for four years. They have stood up well under usage and have fulfilled the objects for which they were designed—adequate separation of patients, protection from drafts and complete visibility of all patients at all times. The movable feature is a definite advantage over the fixed type since the arrangement of the cubicles can be easily changed.

Parents can be kept out of the cubicles in cases where this is necessary. By going behind the unit they can see the child through the glass.

New Automatic Dishwasher Fits in Small Space

For the hospital restaurant with many dishes to wash and kitchen space at a premium, the small automatic dishwasher of simple design and construction is desirable. A recently developed dishwasher of this type has the following dimensions which include the connections, but not the rack tables: width 28½ inches, length 55½ inches, height 57½ inches.

The necessary connections are a ½-inch steam pipe, ¾-inch rinse pipe, 2-inch drain pipe, and a ¾-inch electrical box connection. Gas burners may be used, but are not standard for this ma-



FOOD SERVED
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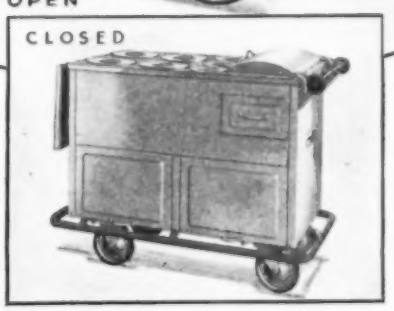
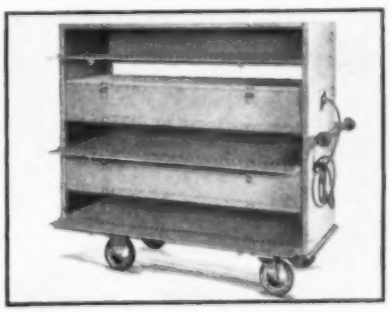
AT THE BEDSIDE • •

Like a traveling cafeteria, this Colson Conveyor moves from ward to ward and room to room. Hot, appetizing food, from its electrically heated and insulated food box is placed before the patient with scarcely a minute's interval. Correct insulation permits the carrying of cold foods, too. We manufacture six types of

Colson "Well Type" Food Conveyors

with different arrangements of containers and capacities varying from 25 to 70 patients. Type A No. 300E, shown, is of all stainless steel construction and is completely bumpered. This style has meat tray with convenient, out of the way, hinged cover that keeps roasts, steaks, chops or fish piping hot; extra large drawer for muffins, etc. and two utility chambers below with new type disappearing door, folding extension shelf for serving. Send today for literature and specifications, as well as quotations and make your food service a source of pride as well as healthful gratification to the patients.





Colson "Tray Type" Food Conveyors

are ideal where routine calls for placing food on trays in diet kitchen and transferring it hot to the bedside. Made in various types with electrically heated as well as cold compartments for salads, etc. . . It is dependable . . . convenient and lasting . . . Send for specifications.

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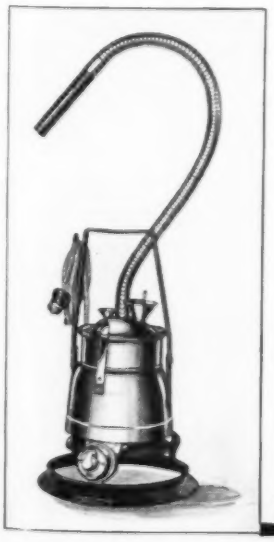
are electrically operated vaporizers that afford a better way of administering health-giving vapors in cases of pneumonia, whooping cough, hay fever, asthma, etc. It is safe because it stands on a wide base on the floor, cannot ignite bedclothes, is safeguarded against trouble in case of boiling dry, mixture of air with steam moderates temperature and bakelite nozzle is never too hot to handle . . .
SEND FOR PARTICULARS



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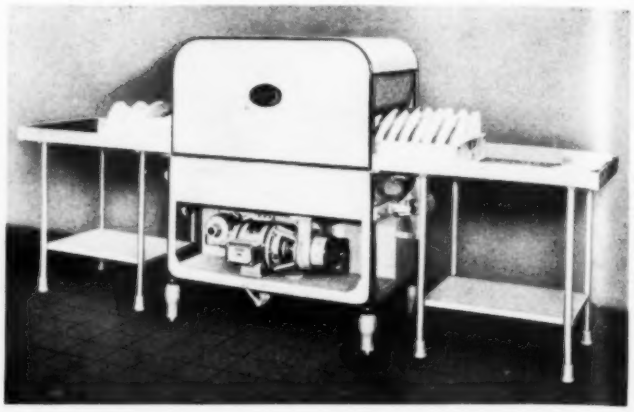
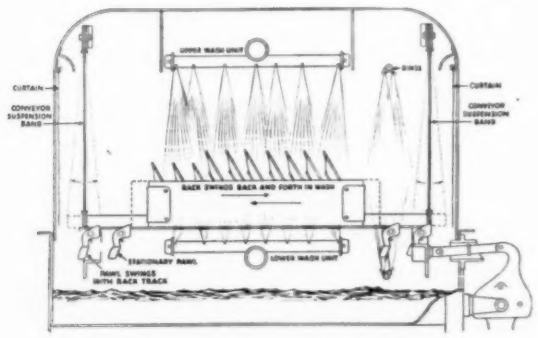


The tables are in place and the dishwasher is ready for operation.

chine. A ¾-h. p. motor of splashproof design is used for driving the pump and pawls. The pump has a capacity of 180 gallons per minute, and has a removable end plate to permit easy cleaning. There are flexible curtains at either end of the hood and also between the rinse and wash compartments, which allow both operations to proceed as the racks move in and out.

The machine is constructed of 12-gauge galvanized iron, 16-gauge nickel-copper alloy or stainless steel. The wash manifolds cover the entire rack area both above and below. Unrestricted slot openings provide distribution and direct the streams at angles to reach all surfaces of the dishes. The double acting rinse arms above and below are operated automatically by the racks as they pass out of the washing compartment. An automatic overflow and an externally operated drain valve regulate the height and amount of liquid in the machine. Adjustable legs compensate for any unevenness in the floor.

The operation of the machine is simple. The operator need only start the rack into the ma-



A sectional view through the dishwasher.

chine. The rack is then caught by the pawls and pushed on to the conveyor which swings back and forth in the washing stream. That either the dishes or the water must move during the washing process is said to be a cardinal principle of effectiveness. The second rack started into the machine pushes the first rack on to another set of

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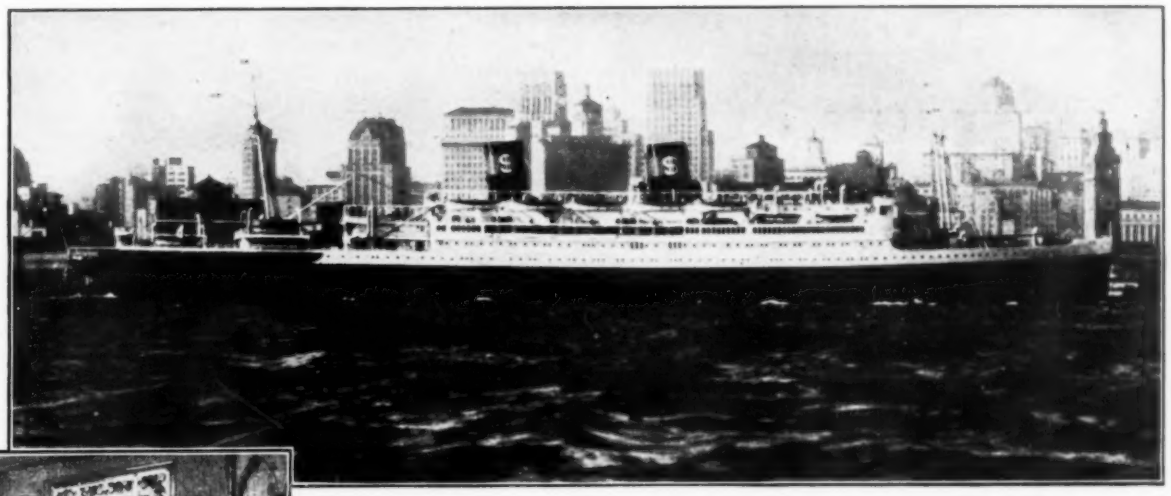

The smoking room of the magnificent S. S. President Hoover waxed with Dri-Brite.

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35,000 square feet of rubber flooring are kept in perfect condition on the S. S. President Hoover with Dri-Brite. Salt air and heavy traffic do not affect the wax finish and the Dri-Brite method of maintaining floors has proven to be the most economical and satisfactory at sea as well as on land.

Dri-Brite Liquid wax has been approved by leading manufacturers of flooring for years. If you are interested in cutting maintenance costs 50% and more on your own floors, use the coupon below for a trial can. On asphalt tile, rubber tile, linoleum, hardwood and painted floors, Dri-Brite gives perfect results.

WARNING!

The success of Dri-Brite Liquid Wax has encouraged imitations. No matter who makes the substitute you are offered, for the protection of your floors use only the original and genuine DRI-BRITE Liquid Wax. Look for the magician on every can.

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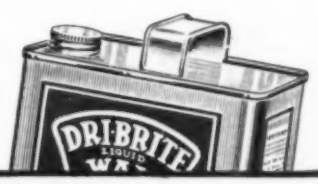

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pawls which in turn engage this rack, push it through the rinse spray and out of the machine. Should the racks become blocked there is no danger of breakage due to pressure from the pawls, because the operating lever automatically disengages from the motor connection. With the obstruction removed, it is a simple operation to reset the machine. The operation of this machine has been simplified so that even the most inexperienced person can operate it.

A Small Laundry Unit of Standard Construction

A balanced laundry unit of small size, and composed of a washer, extractor, and tumbler is intended for use as auxiliary equipment in the large laundry, or may be used for the entire laundry process in the laundry of the small hospital. These machines, although small, are of the standard laundry type, heavy duty equipment, to be used for continuous daily operation.

The washer may be used for small loads of materials that require treatment by special washing formulas, such as linens with various medicinal and blood stains, colored materials, bandages and pads, or it may be used in the sterilizing department if the quantity of septic materials is not large. Due to a complete separation of the two compartments of the washer, it is possible to run two different types of linens that require different formulas through the washing process at the same time.

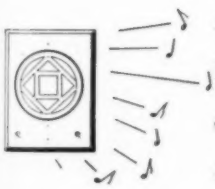
If a progressive operation or formula is desired, the first step in the operation can be carried out on one side of the washer, and the second step on the other side of the washer. The goods in both pockets will be treated simultaneously, and then may be transferred for continuous treatment. Each pocket is isolated insofar as circulation of the solutions is concerned although the entire machine operates as a unit from the same motor.

The washer frame is of heavy iron with all moving parts enclosed in an enamel case. The cylinder is made of noncorrosive metal in two sizes, either 25 by 18 inches or 25 by 36 inches. The larger cylinder is divided into two compartments, each with its individual inlet and dump valves. There are two types of cylinder motion from which to make a selection—an oscillating action that sets up a rocking motion and forces water through the fabric, or a revolving action that allows the clothes to fall into the washing solution.

An entirely enclosed single direction motor connected to the cylinder by a V-cog belt forms the driving mechanism. The current needed for the motor regularly supplied with this equipment is 220-volt, 60-cycle, 3-phase, although it is possible

"MUSIC HATH CHARMS"

. . . *to heal the* HOSPITAL PATIENT



A drab time becomes a happy time—relaxation time—a short time, when a Western Electric Music Reproducing System entertains the convalescent. Getting well then becomes play. This system is serving many modern hospitals at an upkeep cost of only a few cents an hour. **Patients in wards use individual headsets—those in private rooms use either headsets or loud speakers. Records are the source of the program. Whether this or the more elaborate Program Distribution System—which includes radio receiver and microphone as well as music reproducer set—is selected, the faithfulness of tone is unequaled. Every system is scientifically assembled and installed to meet specific requirements—after a careful survey by sound transmission specialists. And Western Electric's reputation as a builder of sound transmission apparatus is world recognized.**

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to use lower voltages, provided the motor is changed to accord with the current supplied. Antifriction bearings, steel drive pinion, and gear reductions running in oil are used throughout.

The extractor, which is 18 inches in diameter and accommodates the load of one compartment of the washer, was designed to extract the washed materials without waiting for the large production equipment of the laundry to be started. The extremely rapid action of the extractor prevents any piling up of washed goods between the washer and the extractor.

This machine has all the mechanical devices

found on large extractors. The balancing principle utilized is the same as that used on large extractors. Safety guards prevent the opening of the basket cover while the machine is in motion, or the starting of the extractor before the cover is closed. Electric manual push button or automatic control may be had. Setting the mechanical timing device releases the brake and starts the machine. After the predetermined time has elapsed, the timer cuts off the current and applies the brake. The case which completely encloses motor and basket is made of noncorrosive metal, as is the basket. Lubrication of the spindle is provided by oil grooves which pump oil to the top of the spindle in a continuous stream. An oil reservoir is at the top of the spindle, and circulation and ventilation keep the oil at the proper temperature.

The tumbler is supplied in three sizes, 36 by 30 inches, 36 by 42 inches and 36 by 48 inches. Low temperature drying with down draft air flow is

employed, the heat being supplied through fin type coils and the temperature controlled by means of an air regulator. The cylinder of this machine is perforated steel, and it has a minimum clearance from the shell to eliminate the possibility of by-passing air currents.

The tumbler has sliding doors throughout, steel trunnions and antifriction bearings. It may be equipped with a timing device that will stop the machine at a prearranged number of minutes, and notify the operator that the load is completely dry. It is equipped with all safety features, and cannot be operated with the door open. A single motor drives both cylinder and fan as one unit. The fan is directly driven, and the cylinder is driven by a V-cog belt.

The following overall dimensions give an indication of the small amount of space that is necessary for the installation of this equipment. The two-compartment washer takes up a floor space of 29½ by 56 inches. With the door closed it is 39 inches high and with it open, 52½ inches. The floor space required for the extractor is 27½ by 33 inches. The height with the cover closed is 36¾ inches and with it open, 54¼ inches. The floor space for the tumbler depends on the length of the cylinder selected, the overall of the machine being 10 inches longer.

A New Kind of Rubber Fabric That Has Many Uses

A new rubber fabric is now being offered the hospital field that involves a principle different from that set by precedent in the manufacture of such materials. It consists of a high quality sheeting to which is welded, on one side only, a process rubber.

In appearance the fabric is attractive and sheer. It is as thin as an ordinary sheet, yet durable in texture. According to the statement of the manufacturer, the basic material is a cotton fabric woven from exceptionally long staples and with the fineness of silk. It is tubfast, sunfast and nonshrinkable. Because of its double surface, it combines a sheet and rubber blanket—one side being cool and comfortable to the patient, the other side being impervious to moisture.

One merit of the new fabric is that it can be laundered in the regular way along with other hospital linens. Because of the high quality of the material, the laundering process will not affect its impenetrability to moisture.

In addition to its use for sheets and pillow cases, this new fabric, because of its lightness and flexibility, should be useful for certain garments, aprons, diapers and even surgical dressings.